

New User Beginner Manual

March 2013





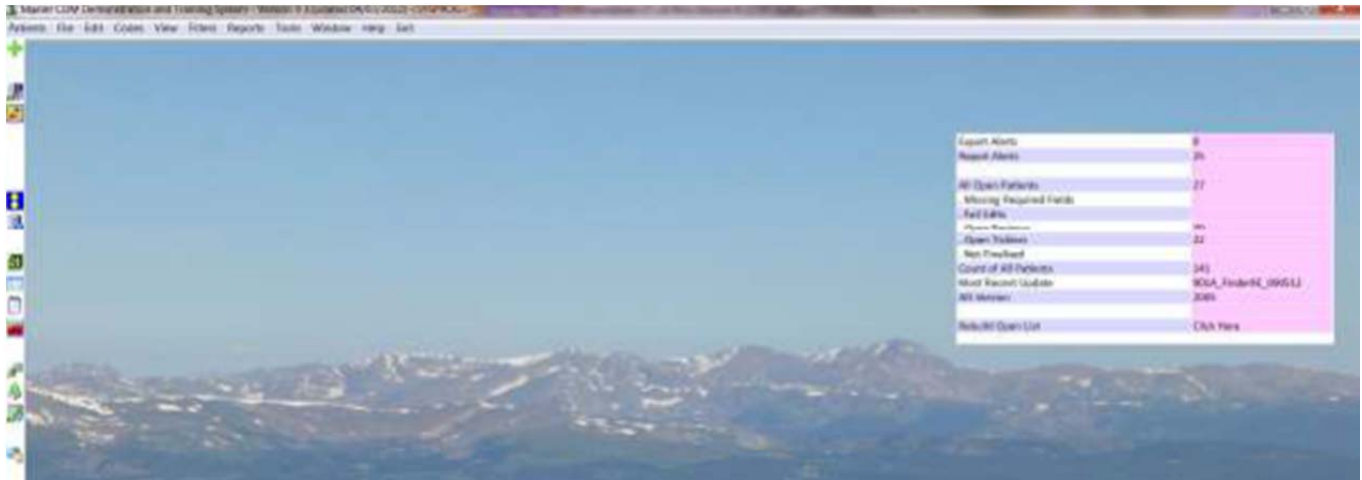
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Opening the System

Welcome to CDM's Version 9 Systems! You will need your User name and Password to enter the system. Your user capabilities are set by your facilities system administrator.

One of the first things you may notice when you open your system is the picture will be a landscape view of the mountain vista from Mount Sherman, Colorado. The second thing you will notice is the System Information Popup on the right side of your screen.



When you first start the registry, in the lower right corner of the screen, an informational Logon Stats Screen appears. You can toggle this screen On/Off by clicking the  icon on the Menu Bar:






















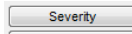
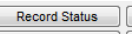
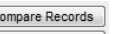
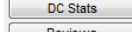
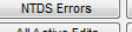
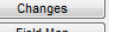
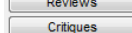
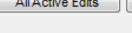
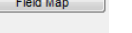
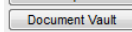
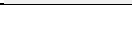
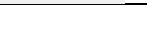


System Administrator Tip: Possibly, your Logon Stats screen does not appear when you start the registry. If you do not see this on start-up, your system administrator may have turned that feature off. If so, just click on the icon shown above to display the Logon Stats screen. Click it again to make it disappear.

The details of the Logon Stats Screen will be explained later. For now take a quick look and see this will give you snapshot of your system.

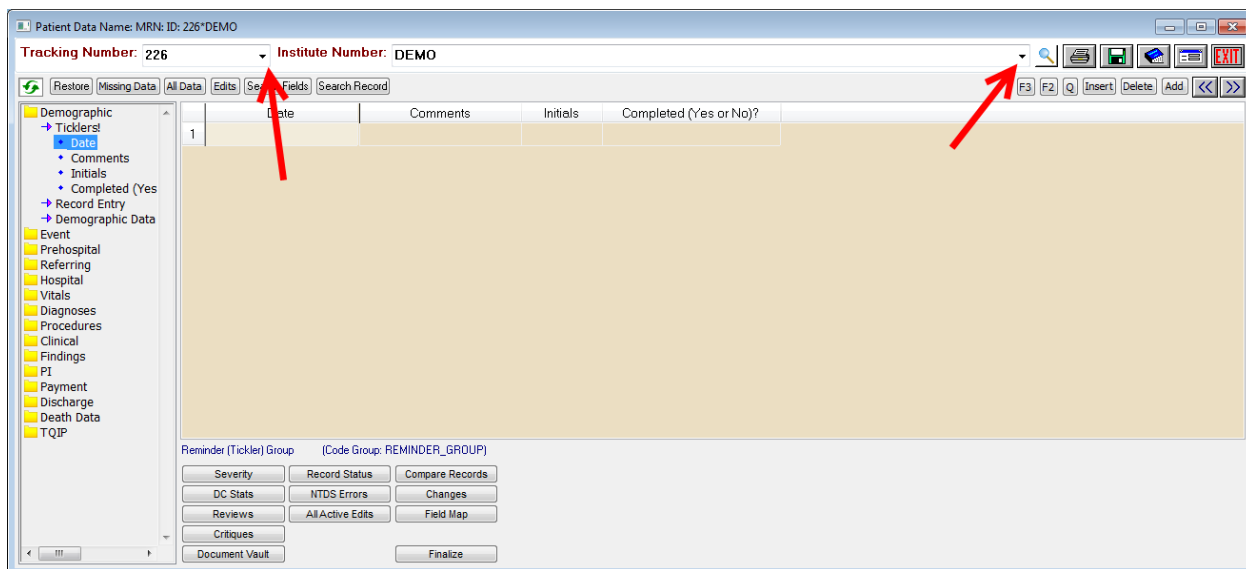
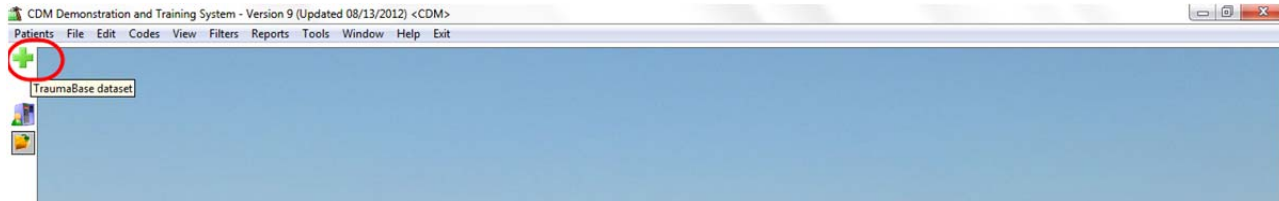
DETAILS FOR THE LOGON STATS SCREEN	
Report Alerts	Number of reports due soon.
Export Alerts	Number of exports due soon.
Open Patients	Number of records with required fields missing.
	Number of records with failing edits.
	Number of records with open reviews.
	Number of records with open ticklers
Count of All Patients	Number of patients in your system
Most Recent Update	Name of the last update installed on your system.
AIS Version	AIS version used in your system
Rebuild Open List	Way to rebuild the list the system uses to display the results of the System Logon Stats.

Data Entry

BEGINNER GOALS FOR FIRST PRACTICE PATIENT YOU ENTER		
	Use <F1> help key at each field	Learn the meaning of your fields
	Use <F2> at all fields with pick-lists	Learn what the pick-lists contain and how to easily find codes on the list
	Using <F2> explore the code finders to help locate codes for complex searches	ECodes AIS/ICD9-10 Finder
	Use green-disk save button to save records and examine edits	
	Understand what a failing edit is and how to fix the data	'*' represents a failing edit
	Understand what a 'free-text' field is and how to edit this type of field using <F3> and <F4>	These fields have no data checking on them. <F3> allows you to zoom open the field and see everything you typed
	Understand what a Multi-value field is and how to select more than one code from the <F2> pick-list	Practice selecting more than one code from a pick list
	Use the different buttons on the data entry screen	<p>Top right      </p> <p>       </p> <p>Top left</p> <p>     </p> <p>Middle Bottom</p> <p>  </p> <p>  </p> <p>  </p> <p></p> <p> </p>

As a new user, one of the first things you might want to do is to enter a patient record, even if data entry may not be part of your job. Entering a patient is essential to become familiar with the data that is collected on patients in your facility and what is available to report out.

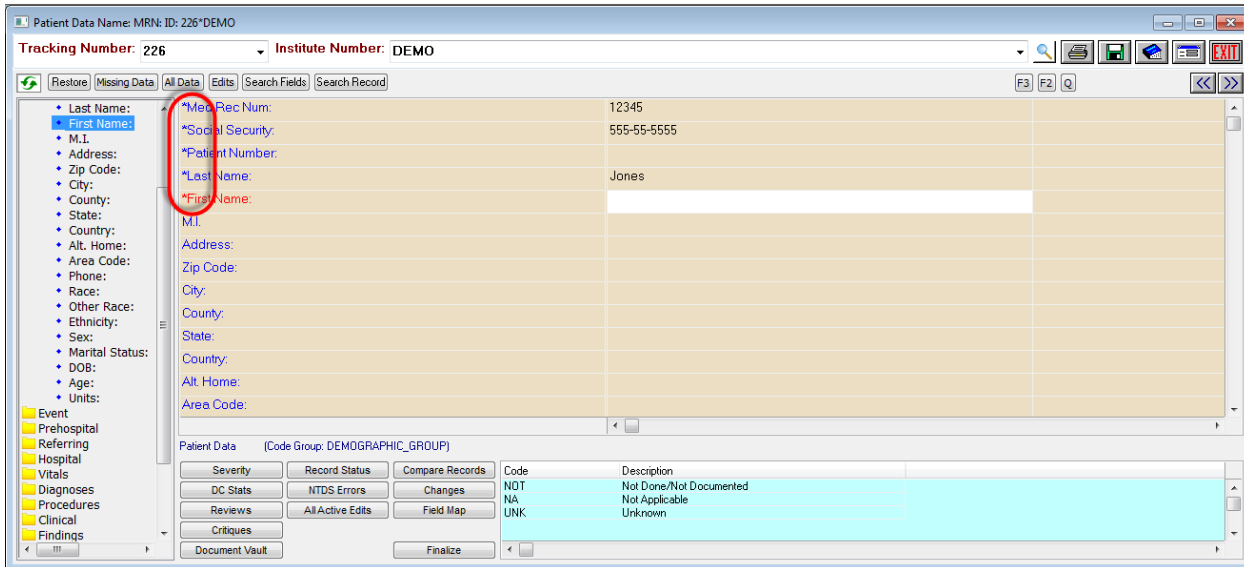
To access the main patient data entry screen, click on the green plus in the upper left corner of the screen.



If you are entering a new patient record, the tracking number (TRACKING_NO) will default to the next sequential tracking number. The system will keep track of this for you and will automatically put the next unused tracking number into this field. It will also put the INSTITUTE_NO of your facility in the Institute Number field.

To navigate through the data fields use the tab key, ENTER key on your keyboard or your mouse. Notice some fields have an asterisk, *, before the description. This designates a field that is required as part of a national, state or regional export and must be filled in with a valid response. Also notice the text turns red and the data entry field is white when the cursor is on the field.

On the left side of the screen, the groups of fields or categories are identified by yellow folders. To expand these folders just click on it. Within some groups, there will be subgroups. These groups and subgroups are called Code Groups. These are set up to be logical for your data entry process and can be modified. Below the groups (yellow folders) and subgroups (arrows) are the fields.



Patient Data Name: MRN: ID: 226*DEMO
 Tracking Number: 226 Institute Number: DEMO

Restore Missing Data All Data Edits Search Fields Search Record

*Med. Rec Num: 12345
 *Social Security: 555-55-5555
 *Patient Number:
 *Last Name: Jones
 *First Name:
 M.I.
 Address:
 Zip Code:
 City:
 County:
 State:
 Country:
 Alt. Home:
 Area Code:
 Phone:
 Race:
 Other Race:
 Ethnicity:
 Sex:
 Marital Status:
 DOB:
 Age:
 Units:

Event
 Prehospital
 Referring
 Hospital
 Vitals
 Diagnoses
 Procedures
 Clinical
 Findings

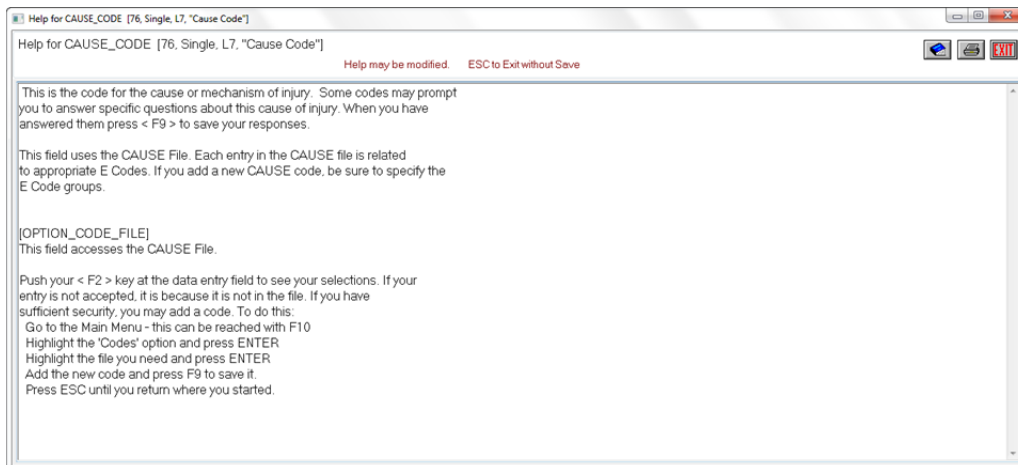
Patient Data (Code Group: DEMOGRAPHIC_GROUP)

Code	Description
NOT	Not Done/Not Documented
NA	Not Applicable
UNK	Unknown

Severity Record Status Compare Records Code
 DC Stats NTDS Errors Changes NOT
 Reviews All Active Edits Field Map NA
 Critiques Finalize UNK

Some fields are free text and you type in the appropriate answer, like Last Name, First Name, and Medical Record Number. Other fields have specific answers or codes. For instance, let's look at the field RACE. Tab through the fields until you get to RACE. Once on the RACE field, press the F2 key on your keyboard and a popup will appear with the code choices for that field. Or you can select the appropriate code in the lower right corner of the screen.

Additional information regarding the field can be found by pressing the F1 key on your keyboard. Place your cursor in the field you have a question about and then press F1. Below is an example of what you would see if you pressed F1 while on the Cause_Code field.



Help for CAUSE_CODE [76, Single, L7, "Cause Code"]

Help for CAUSE_CODE [76, Single, L7, "Cause Code"] Help may be modified. ESC to Exit without Save

This is the code for the cause or mechanism of injury. Some codes may prompt you to answer specific questions about this cause of injury. When you have answered them press < F9 > to save your responses.

This field uses the CAUSE File. Each entry in the CAUSE file is related to appropriate E Codes. If you add a new CAUSE code, be sure to specify the E Code groups.

[OPTION_CODE_FILE]
 This field accesses the CAUSE File.

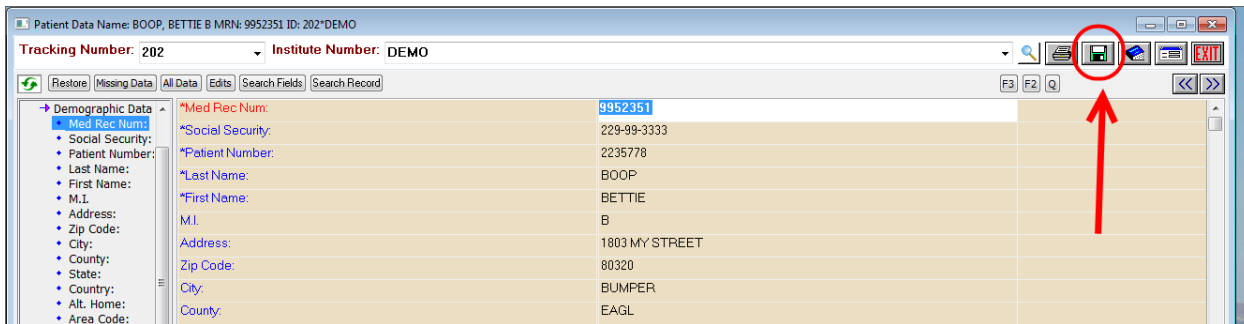
Push your < F2 > key at the data entry field to see your selections. If your entry is not accepted, it is because it is not in the file. If you have sufficient security, you may add a code. To do this:
 Go to the Main Menu - this can be reached with F10
 Highlight the "Codes" option and press ENTER
 Highlight the file you need and press ENTER
 Add the new code and press F9 to save it.
 Press ESC until you return where you started.

Continue through all the data entry fields, entering data along the way until all the fields have data.



As you move through data entry from yellow folder to yellow folder your data is being saved automatically. Your system tracks every time the record is saved, who was logged in at the save and what was changed in the record at the time of save; this is called Mirroring. There is a way to retrieve/restore a Mirror copy of a record if needed. (See CDM Support for details on mirroring.)

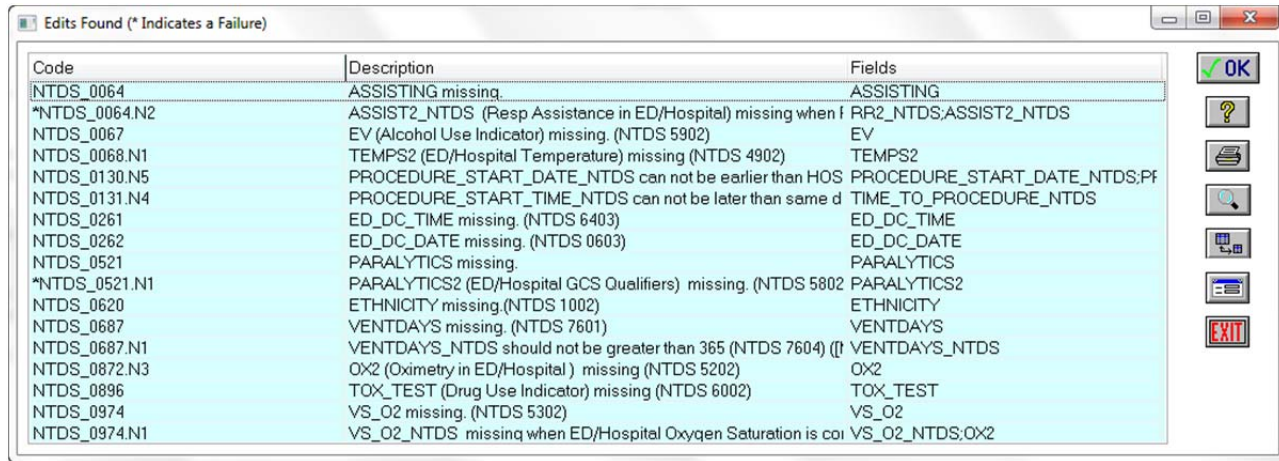
Once all the data has been entered, or more frequently, you should manually save the record. To save your record, press the green diskette button. This button will save the record and then run through the edits. Edits check to make sure you have required fields filled in correctly; edits look at missing data, answers are logical and date and time accuracy.



If there are edits you will see this window with a list of the edits and fields that need correction. You may print this out by clicking on the print button (3rd button from the top.)

NOTE: If you want to read the full description a specific edit click on the edit and then on the magnifying glass button located on the right 4th from the bottom.

NOTE: Some edits allow you to double click on them to go directly to the data and correct the error (some edits are calculated fields and therefore require you to go back to the record and fix fields manually.)

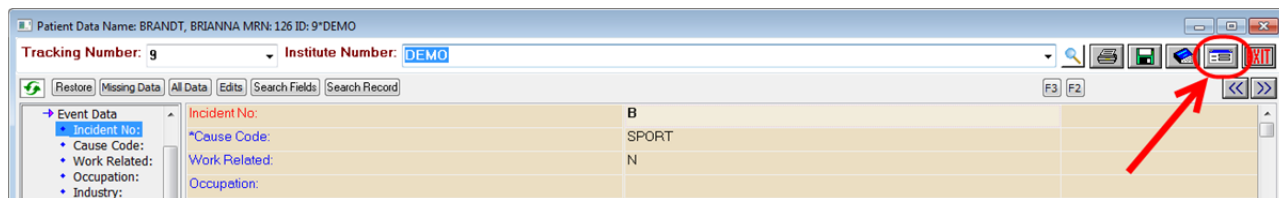


Code	Description	Fields
NTDS_0064	ASSISTING missing.	ASSISTING
*NTDS_0064.N2	ASSIST2_NTDS (Resp Assistance in ED/Hospital) missing when f	RR2_NTDS;ASSIST2_NTDS
NTDS_0067	EV (Alcohol Use Indicator) missing. (NTDS 5902)	EV
NTDS_0068.N1	TEMPS2 (ED/Hospital Temperature) missing (NTDS 4902)	TEMPS2
NTDS_0130.N5	PROCEDURE_START_DATE_NTDS can not be earlier than HOS	PROCEDURE_START_DATE_NTDS;PF
NTDS_0131.N4	PROCEDURE_START_TIME_NTDS can not be later than same d	TIME_TO_PROCEDURE_NTDS
NTDS_0261	ED_DC_TIME missing. (NTDS 6403)	ED_DC_TIME
NTDS_0262	ED_DC_DATE missing. (NTDS 0603)	ED_DC_DATE
NTDS_0521	PARALYTICS missing.	PARALYTICS
*NTDS_0521.N1	PARALYTICS2 (ED/Hospital GCS Qualifiers) missing. (NTDS 5802)	PARALYTICS2
NTDS_0620	ETHNICITY missing.(NTDS 1002)	ETHNICITY
NTDS_0687	VENTDAYS missing. (NTDS 7601)	VENTDAYS
NTDS_0687.N1	VENTDAYS_NTDS should not be greater than 365 (NTDS 7604) (f)	VENTDAYS_NTDS
NTDS_0872.N3	OX2 (Oximetry in ED/Hospital.) missing (NTDS 5202)	OX2
NTDS_0896	TOX_TEST (Drug Use Indicator) missing (NTDS 6002)	TOX_TEST
NTDS_0974	VS_O2 missing. (NTDS 5302)	VS_O2
NTDS_0974.N1	VS_O2_NTDS missing when ED/Hospital Oxygen Saturation is coi	VS_O2_NTDS;OX2

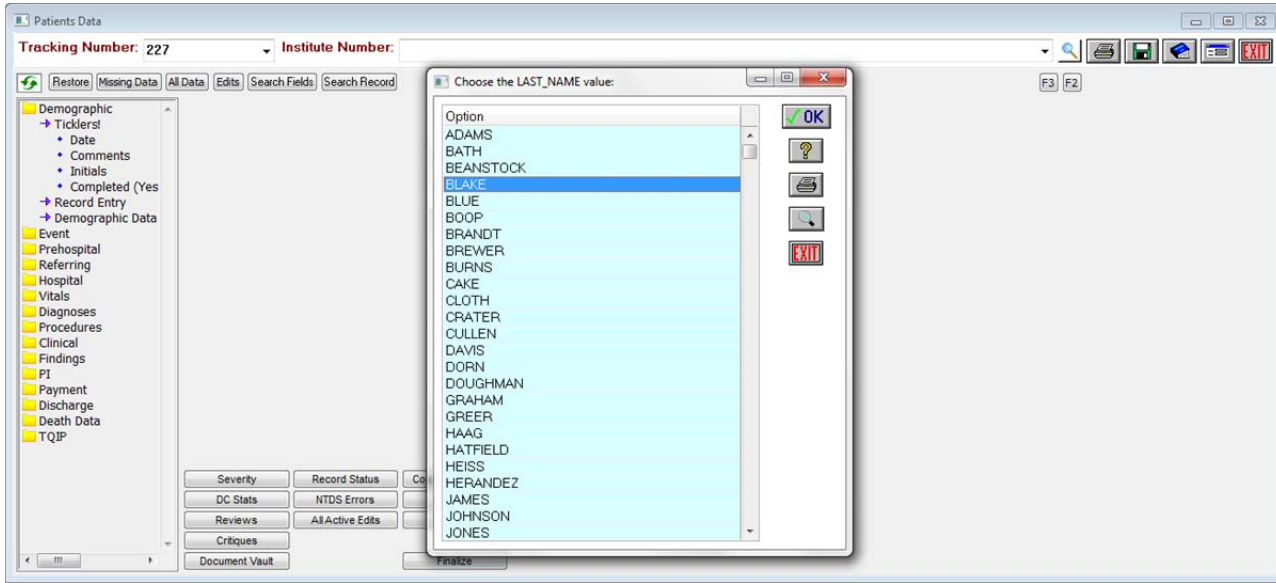
There are specific documents regarding edits. Generally if all the fields are filled out you should have no edits in the record.

NOTE: Any edit that has a ‘*’ star in front of it indicates it is a failing edit. These are the most important edits to pay attention to and ones you have to correct before your data can be exported to your region/state or NTDS/TQIP groups. If possible, fix all failing starred edits at the time of data entry so that exporting will go smoothly later.

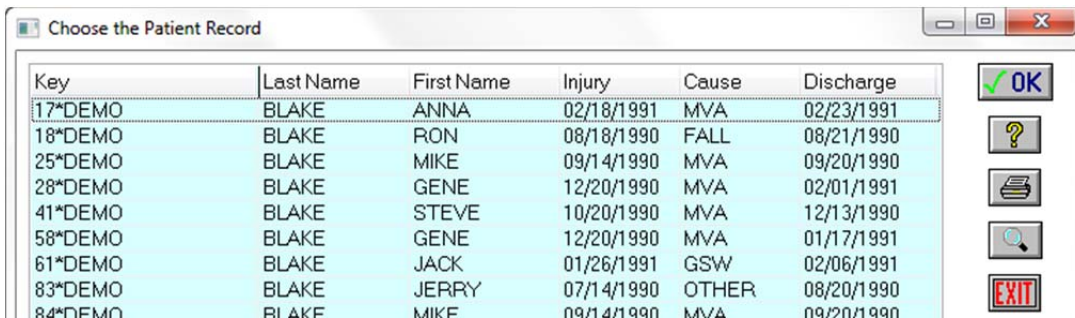
After you have completed a record and are ready to enter another record, click on the ‘Save Data Then Clear Form’ button. This will save the record and clear the data entry screen so you may begin a new record.



If you want to look up a record to finish or check, click on the down arrow to the right of the Tracking Number or click on the magnifying glass to the right of the Institute number. This will bring up a list of last names or the alphabet (depending on how your system is setup.) You can then select the name or letter and begin to drill down to the record. Highlight the last name and click OK.



If there is more than one record with the last name of Blake, you will see:



Double click or highlight the record you wish to look at or modify and then click OK. If you know the Medical Record Number of the patient you can enter in a period and the number at the TRAUMA NUMBER field and enter to find the record. For example .676767 → ENTER will find the patient with the MRN of 676767.

Data Entry Finders

Within the data entry, CDM systems have tools to help with the selection of fields where there may be hundreds of choices. E Codes and ICD codes are examples. These are explained below.

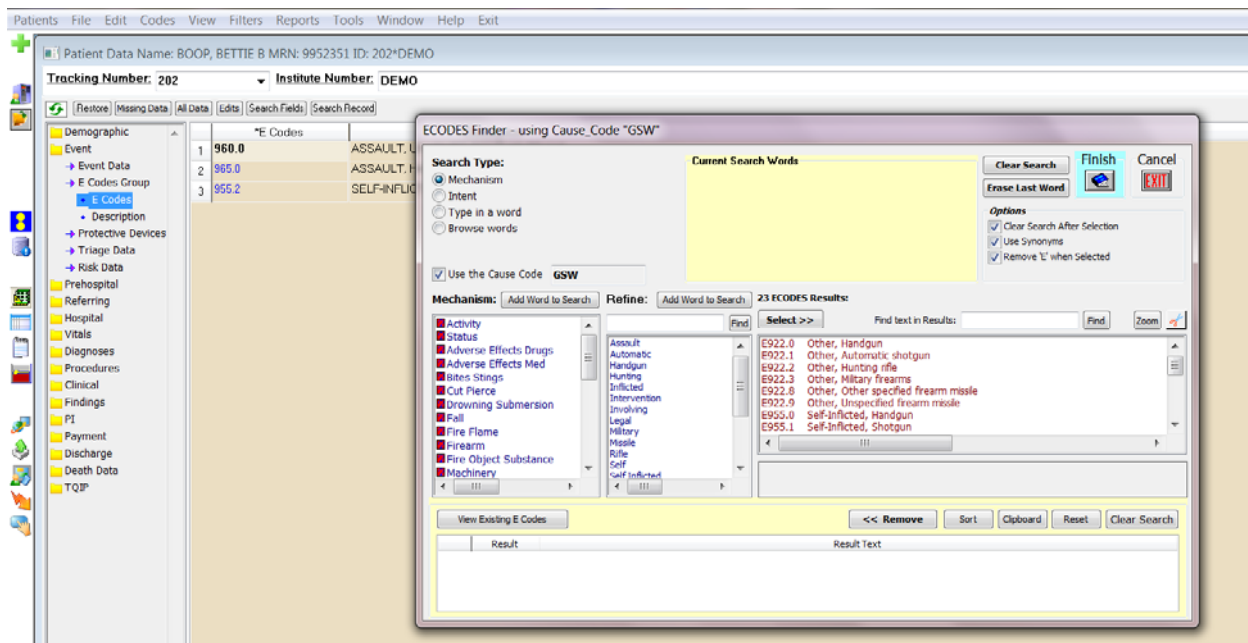
E-Code Finder:

This is an updated look-up Wizard used during data entry.

This Wizard correlates to the CAUSE OF INJURY (Cause_Code) you have assigned to a patient. When you first open this screen during data entry using the <F2> key, you will see the branch of the E-Codes for the Cause_Code you selected. Cause of Injury is what CDM systems call 'Mechanism'. However if you wish to search for codes via 'Intent', 'Type in a word', or, 'Browse words' you can do this as well.

This look-up finder is similar to the AIS/ICD9 Version 9 finder used when entering in diagnoses information.

From this window you can see the 'Current Search Words' you have used in the yellow section; you can 'Erase Last Word' from your search easily if you have gone down the wrong path. Coding works from left to right until you see the code you are searching for. When you have selected your first E-Code you can 'Clear Search' and select an additional E-Code, or, 'Finish'.

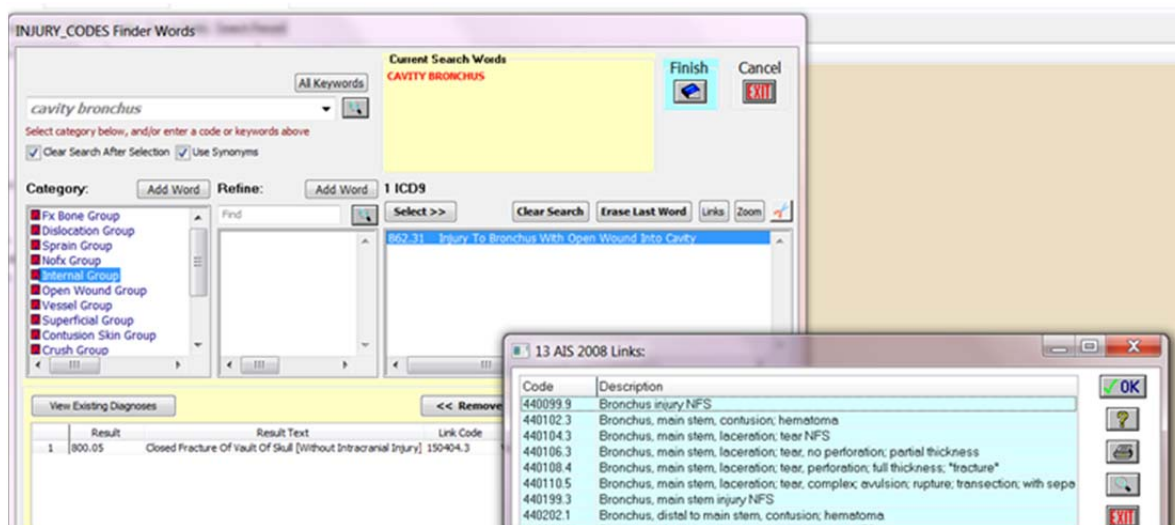


The bottom of the Wizard allows easy editing to your list by allowing you to remove codes you have selected, sort the order of the current codes, reset and clear search the entire search window so you can start again, and, 'View Existing E-Codes' you may have selected prior to going into the E-Code finder.

The Finder 9 AIS/ICD9 coder:

The new Finder 9 allows you to easily choose ICD9/AIS codes. Built on the work CDM does exclusively for AAAM, you will be able to point-and-click your way through this wizard returning your choices easily and directly to Diagnoses data entry screen.

This wizard will **automatically** fill in your Diagnoses table.



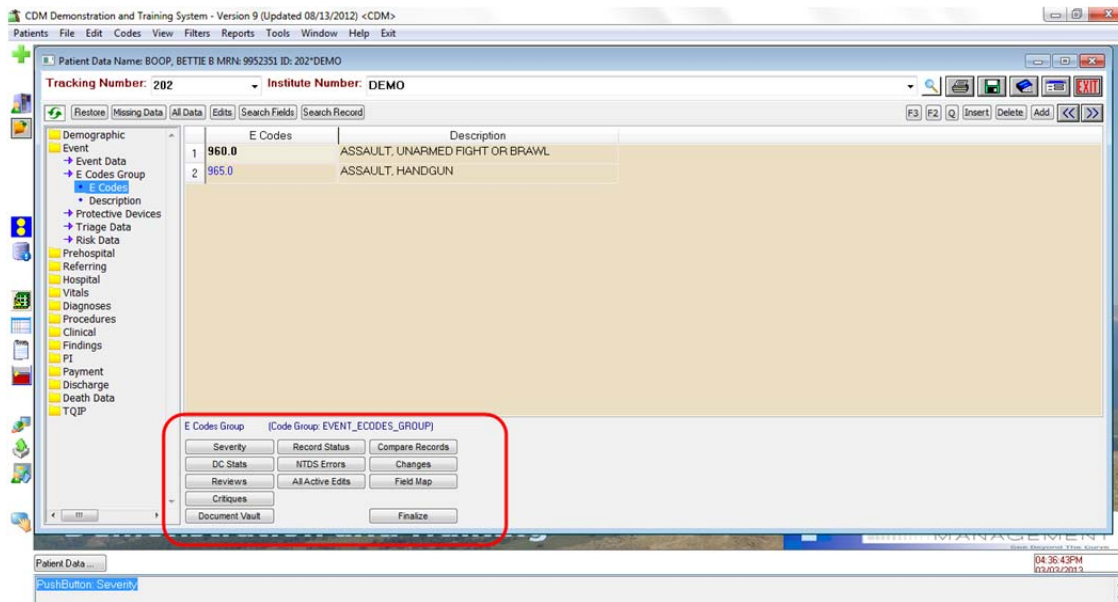
You can also type in text to search, refine searches, re-sort diagnoses that have been selected, and use synonyms during your search!

V9 Finder:

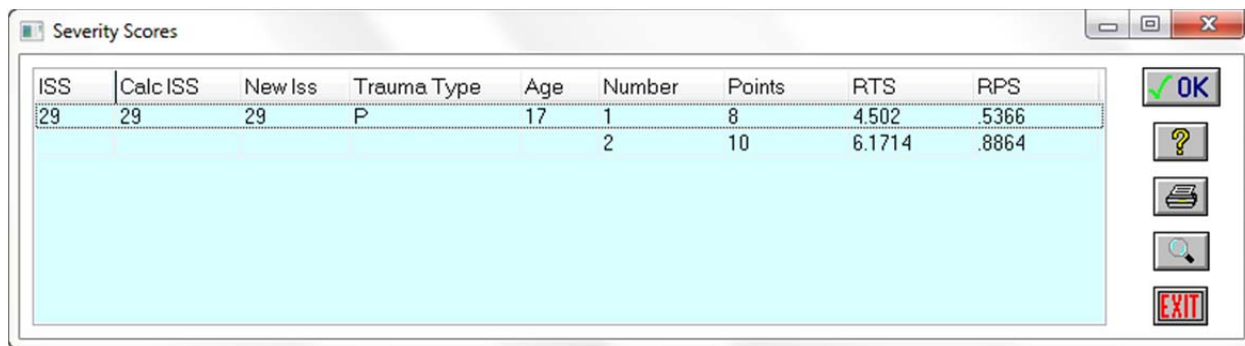
- ◆ Allows typing in of keywords
- ◆ Easy view of the 'Current Search Words'
- ◆ Clipboard for easy pasting
- ◆ Re-Sorting of selected Diagnoses
- ◆ Clear Search functionality to remove the most recent search you have done
- ◆ Reset to clear all selected codes
- ◆ Allows display of AIS98 links
- ◆ Allow search to be driven by AIS or ICD9!

Patient Information Buttons

At the bottom of the Patient Data Entry Screen are a group of buttons. Each of these buttons presents specific information about the patient.

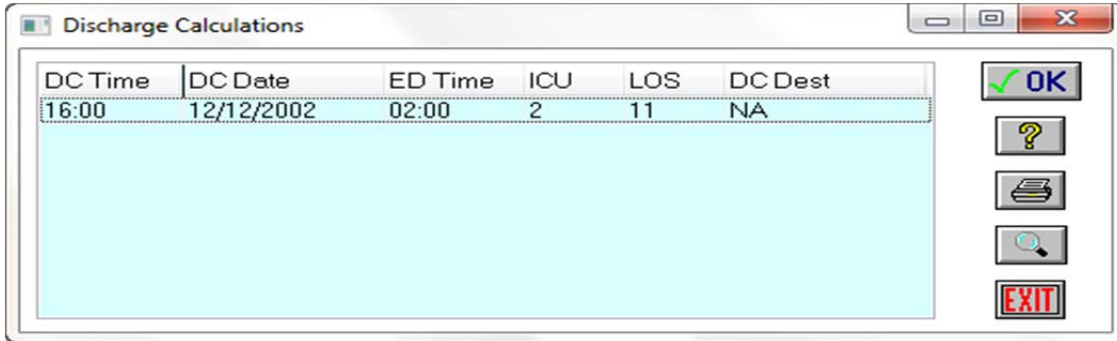


Severity – This button displays the Injury Severity Score (ISS) entered, calculated ISS, New ISS, Age, vital sign number, injury points, Revised Trauma Score and Revised Probability of Survival.



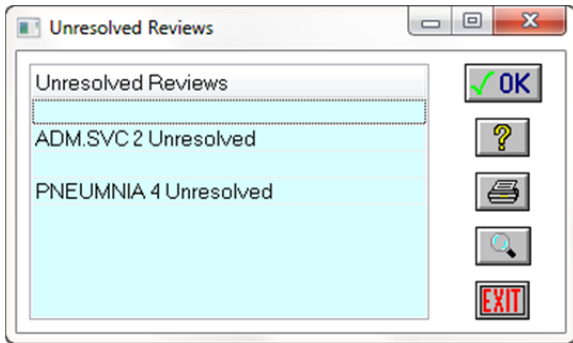
ISS	Calc ISS	New Iss	Trauma Type	Age	Number	Points	RTS	RPS
29	29	29	P	17	1	8	4.502	5366
					2	10	6.1714	8864

DC Stats – Discharge information: discharge time, discharge date, time in ED, length of stay and discharge destination if transferred to a higher level of care.



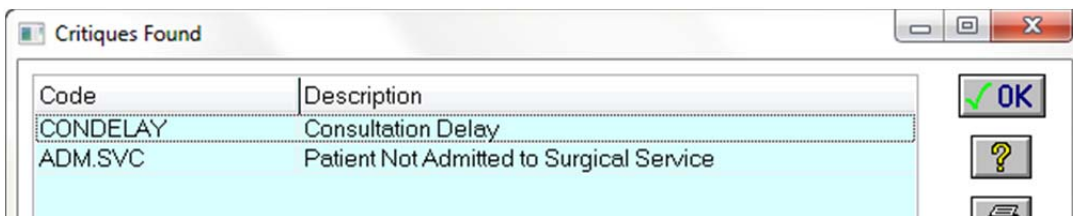
DC Time	DC Date	ED Time	ICU	LOS	DC Dest
16:00	12/12/2002	02:00	2	11	NA

Reviews – Lists unresolved reviews for this patient.



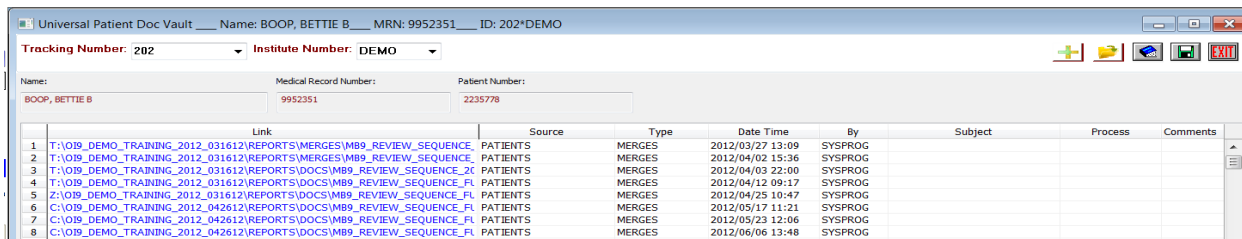
Unresolved Reviews
ADM.SVC 2 Unresolved
PNEUMNIA 4 Unresolved

Critiques – List critiques for this patient.



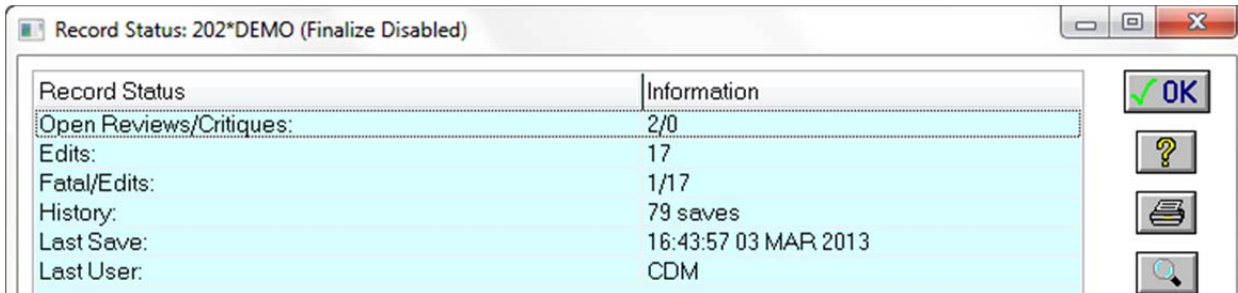
Code	Description
CONDELAY	Consultation Delay
ADM.SVC	Patient Not Admitted to Surgical Service

Document Vault – Click on this button and the documents linked to this patient from the document vault will be listed.

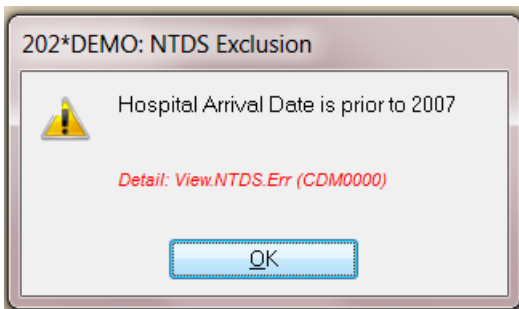


Link	Source	Type	Date Time	By	Subject	Process	Comments
T:\O19_DEMO_TRAINING_2012_031612\REPORTS\MERGES\MB9_REVIEW_SEQUENCE_ PATIENTS	PATIENTS	MERGES	2012/03/27 13:09	SYSPROG			
T:\O19_DEMO_TRAINING_2012_031612\REPORTS\MERGES\MB9_REVIEW_SEQUENCE_ PATIENTS	PATIENTS	MERGES	2012/04/02 15:36	SYSPROG			
T:\O19_DEMO_TRAINING_2012_031612\REPORTS\DOCS\MB9_REVIEW_SEQUENCE_2 PATIENTS	PATIENTS	MERGES	2012/04/03 22:00	SYSPROG			
T:\O19_DEMO_TRAINING_2012_031612\REPORTS\DOCS\MB9_REVIEW_SEQUENCE_FL PATIENTS	PATIENTS	MERGES	2012/04/12 09:17	SYSPROG			
Z:\O19_DEMO_TRAINING_2012_031612\REPORTS\DOCS\MB9_REVIEW_SEQUENCE_FL PATIENTS	PATIENTS	MERGES	2012/04/25 10:47	SYSPROG			
C:\O19_DEMO_TRAINING_2012_042612\REPORTS\DOCS\MB9_REVIEW_SEQUENCE_FL PATIENTS	PATIENTS	MERGES	2012/05/17 11:21	SYSPROG			
C:\O19_DEMO_TRAINING_2012_042612\REPORTS\DOCS\MB9_REVIEW_SEQUENCE_FL PATIENTS	PATIENTS	MERGES	2012/05/23 12:06	SYSPROG			
C:\O19_DEMO_TRAINING_2012_042612\REPORTS\DOCS\MB9_REVIEW_SEQUENCE_FL PATIENTS	PATIENTS	MERGES	2012/06/06 13:48	SYSPROG			

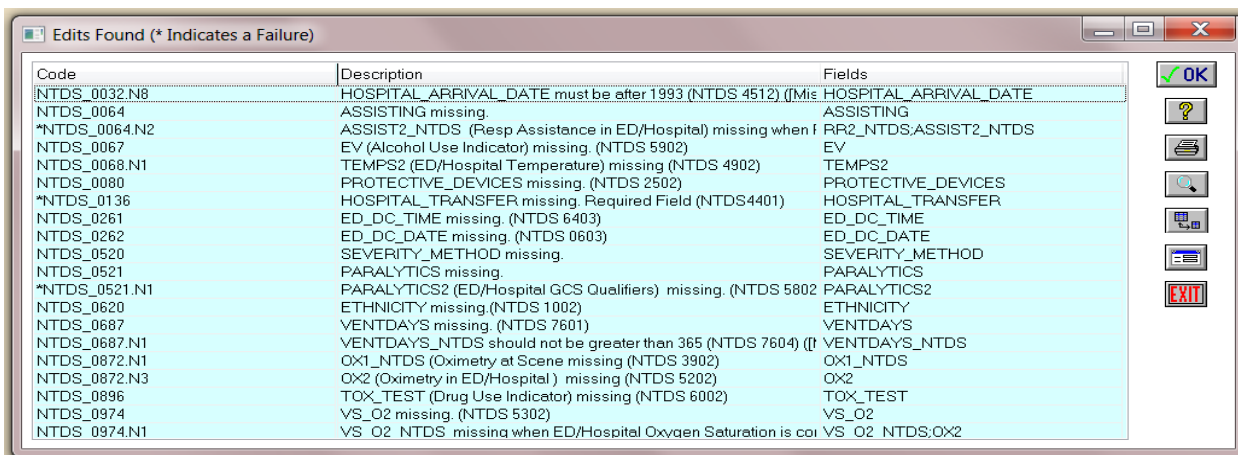
Record Status – This list the open review and critiques, the number of edits, the number of failing edits, the history of number of times the record has been saved, the time and date of the last save and the last user to save this record.



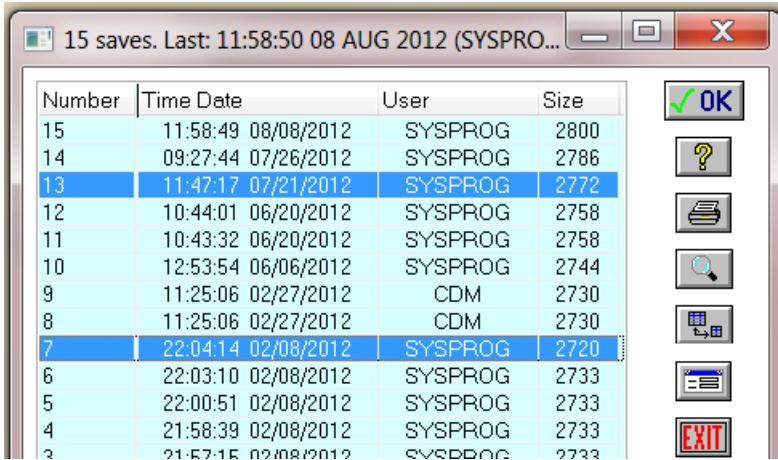
NTDS Errors – This will list the NTDS edits for this record or tell you that you don't failing NTDS edits.



All Active Edits – This will list all the active edits for this record.

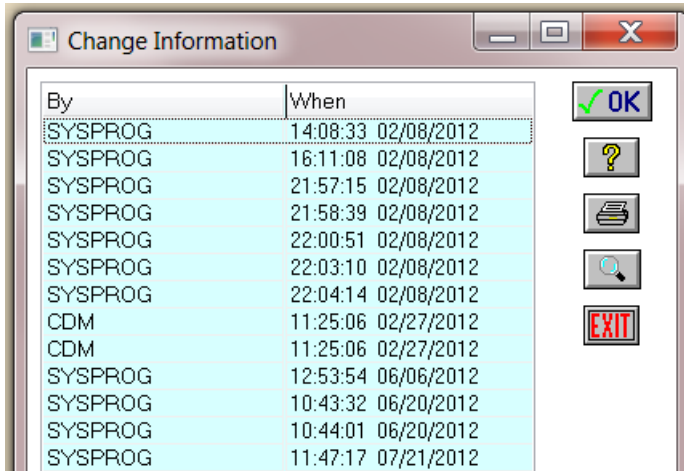


Compare Records – This process is called ‘mirroring’ and is way to look at saved versions of the record, see how often a record has been saved and restore records from past saves. Call Support for help with this.



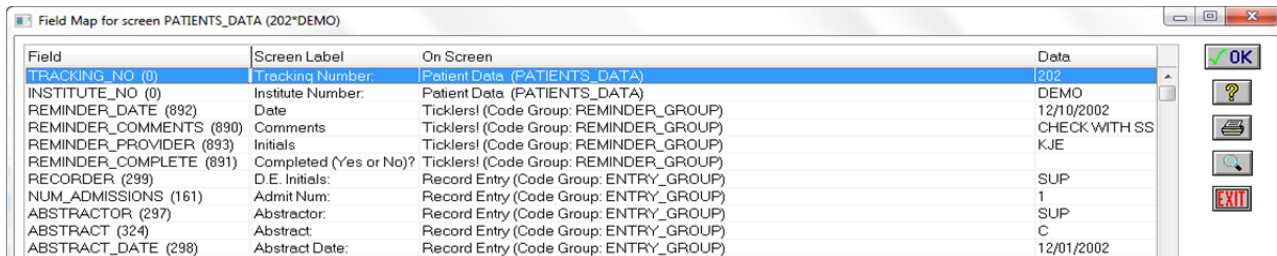
Number	Time Date	User	Size
15	11:58:49 08/08/2012	SYSPROG	2800
14	09:27:44 07/26/2012	SYSPROG	2786
13	11:47:17 07/21/2012	SYSPROG	2772
12	10:44:01 06/20/2012	SYSPROG	2758
11	10:43:32 06/20/2012	SYSPROG	2758
10	12:53:54 06/06/2012	SYSPROG	2744
9	11:25:06 02/27/2012	CDM	2730
8	11:25:06 02/27/2012	CDM	2730
7	22:04:14 02/08/2012	SYSPROG	2720
6	22:03:10 02/08/2012	SYSPROG	2733
5	22:00:51 02/08/2012	SYSPROG	2733
4	21:58:39 02/08/2012	SYSPROG	2733
3	21:57:15 02/08/2012	SYSPROG	2733

Changes – This is another way to look at saved versions of the record. Call Support for help with this.



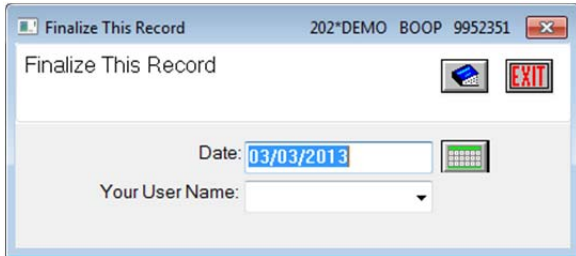
By	When
SYSPROG	14:08:33 02/08/2012
SYSPROG	16:11:08 02/08/2012
SYSPROG	21:57:15 02/08/2012
SYSPROG	21:58:39 02/08/2012
SYSPROG	22:00:51 02/08/2012
SYSPROG	22:03:10 02/08/2012
SYSPROG	22:04:14 02/08/2012
CDM	11:25:06 02/27/2012
CDM	11:25:06 02/27/2012
SYSPROG	12:53:54 06/06/2012
SYSPROG	10:43:32 06/20/2012
SYSPROG	10:44:01 06/20/2012
SYSPROG	11:47:17 07/21/2012

Field Map – This button will display a list of all the fields on the Patient Data Entry Screen in the order they appear. The last column will display the data in each field. You can also print this out.



Field	Screen Label	On Screen	Data
TRACKING_NO (0)	Tracking Number:	Patient Data (PATIENTS_DATA)	202
INSTITUTE_NO (0)	Institute Number:	Patient Data (PATIENTS_DATA)	DEMO
REMINDER_DATE (892)	Date	Ticklers! (Code Group: REMINDER_GROUP)	12/10/2002
REMINDER_COMMENTS (890)	Comments	Ticklers! (Code Group: REMINDER_GROUP)	CHECK WITH SS
REMINDER_PROVIDER (893)	Initials	Ticklers! (Code Group: REMINDER_GROUP)	KJE
REMINDER_COMPLETE (891)	Completed (Yes or No)?	Ticklers! (Code Group: REMINDER_GROUP)	
RECORDER (299)	D.E. Initials:	Record Entry (Code Group: ENTRY_GROUP)	SUP
NUM_ADMISSIONS (161)	Admit Num:	Record Entry (Code Group: ENTRY_GROUP)	1
ABSTRACTOR (297)	Abstractor:	Record Entry (Code Group: ENTRY_GROUP)	SUP
ABSTRACT (324)	Abstract:	Record Entry (Code Group: ENTRY_GROUP)	C
ABSTRACT_DATE (298)	Abstract Date:	Record Entry (Code Group: ENTRY_GROUP)	12/01/2002

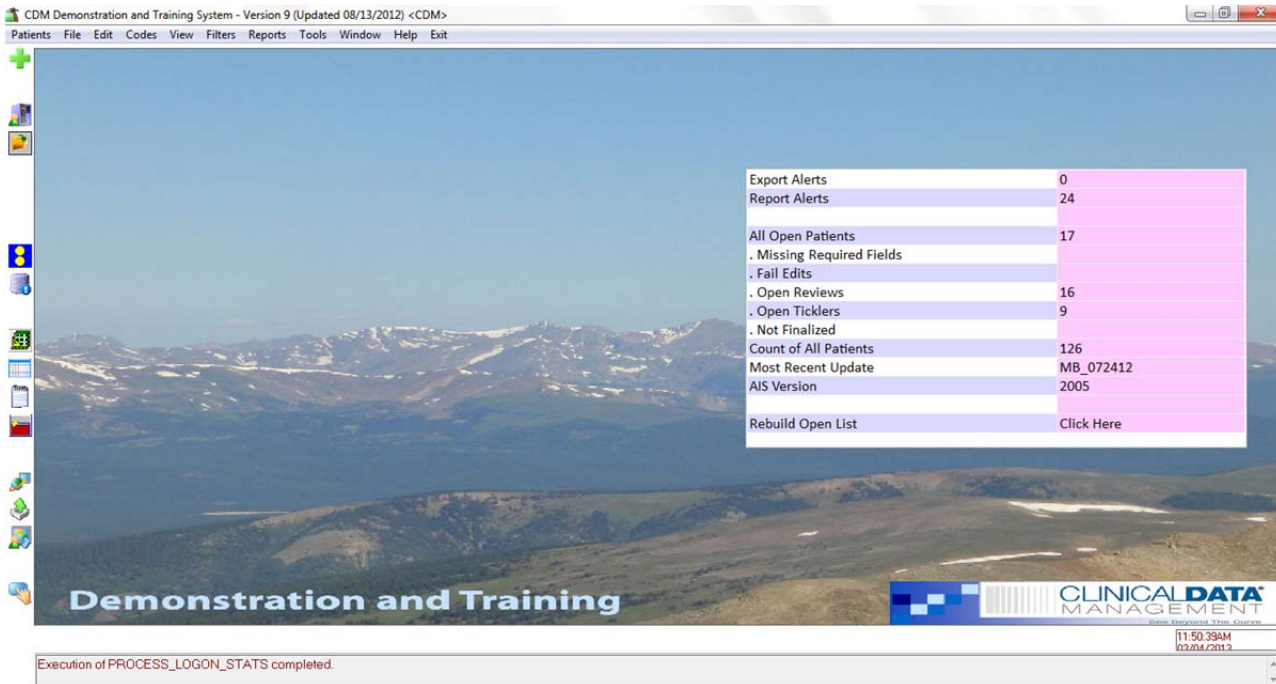
Finalize – You can finalize a record by clicking on the Finalize button. Enter the date and select your username. Use this when a record is complete and no further changes are anticipated.



Logon Stats Screen

I. Understanding the Information Presented on the Logon Stats Screen:

The Logon Stats Screen is an interactive tool for you to both count and to access Exports, Reports, and patient records that are “Open”. Open Patients consist of those records who either have blank data in the ‘Required Fields’, Fail Edits, Open Reviews, or Open Ticklers. We will address each of these items in detail:



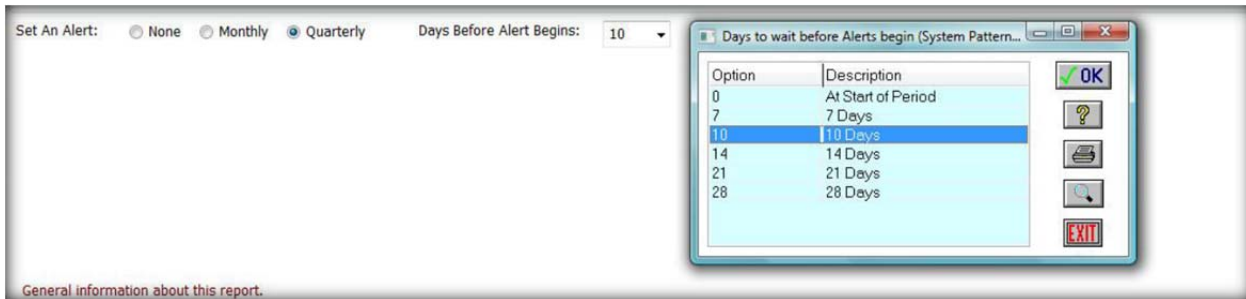
Export Alerts	0
Report Alerts	24
All Open Patients	17
. Missing Required Fields	
. Fail Edits	
. Open Reviews	16
. Open Ticklers	9
. Not Finalized	
Count of All Patients	126
Most Recent Update	MB_072412
AIS Version	2005
Rebuild Open List	Click Here

Execution of PROCESS_LOGON_STATS completed.

11:50:39AM
02/04/2012

A. Report and Export Alerts:

In most of your Reports and Exports, there is now a section to set Alerts which remind you to run the specific process before its due date. That new section is found on the bottom of the 'General' tab and looks as follows:



Once the Alert has been turned on, that Report or Export will be added to the appropriate "Alert" lines of the Logon Stats Screen.

Click on the number to recall the pick-list of Reports, or to see the list of Exports with Alerts.

B. Open Patients:

Patients are considered "Open" if any one of four conditions exist: any required fields are missing, there are fail Edits, there are open Reviews, or there are open Ticklers.

*Reporting Tip: The symbolic Field **RECORD_OPEN_SUMMARY** lists which of these four conditions exist on "Open" Patients. This field is updated every time the Patient record is saved and every time the Patients_Open list is remade. Use the report wizard detail report to select this field to view.*

1. Missing Required Fields. There is a record in your Account_Control file called REQUIRED_FIELDS. In this file, if you are part of a Regional or State System, are the fields that are present in the export to the State or Region. If you are a hospital that does not report to a State or Region, this may be a generic list of important fields containing data for each patient.

Click on the number to recall the pick-list of Patients with missing required data, to view or edit them.

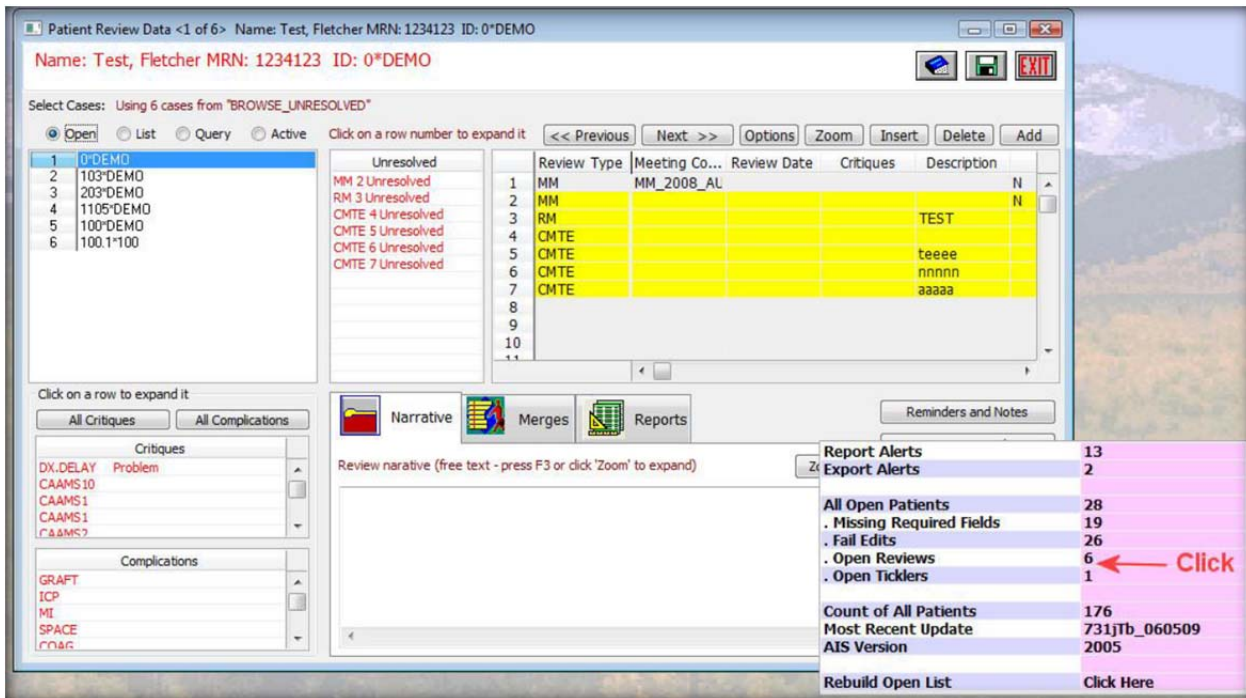
System Administrator Tip: You may adjust this list, to either add additional fields considered important at your hospital, or to delete fields from the list that you do not wish to be in that list, you may easily do so by typing at TCL (F5): `CHANGE_REQUIRED_FIELDS <run>`

*Reporting Tip: The symbolic field **RECORD_FIELDS** contains the list of all Required Fields that are missing. This field is updated every time the Patient record is saved and every time the Patients_Open list is remade. Use the report wizard detail report to select this field to view.*

2. Fail Edits. Any Patient Record with Fail Edits (EDITS_FAIL) will appear on this list. Click on the number to recall the pick-list of Patients with Fail Edits, to view or edit them.

3. Open Reviews. If there is no closing date (REVIEW_RESOLVE) for every Review on this Patient, they will be counted on this line.

Click on the number to open your new PIPS screen, the Performance Improvement Screen, to display and edit the list of Patients with Open Reviews. A separate document fully explaining the PIPS Screen was released with the 7.37 update. Please refer to that document regarding more details about the screen seen below:

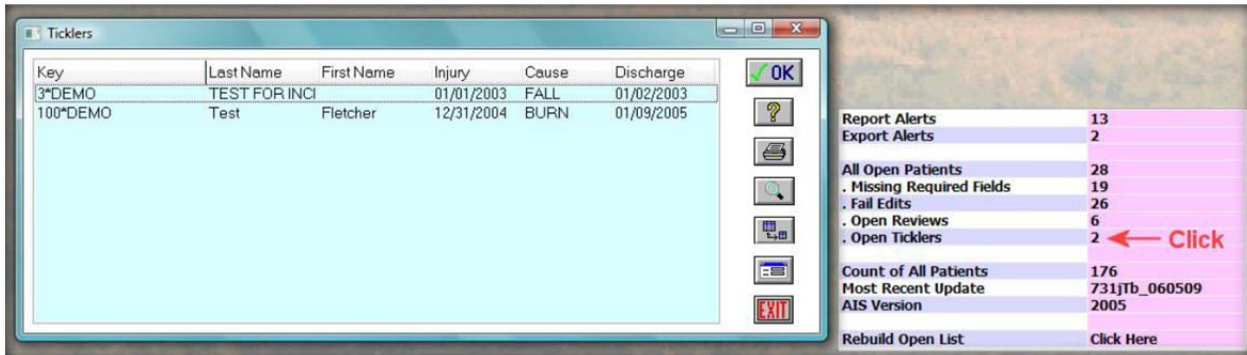


The screenshot displays the 'Patient Review Data' window for a patient named 'Test, Fletcher MRN: 1234123 ID: 0*DEMO'. The interface includes a 'Select Cases' section with radio buttons for 'Open', 'List', 'Query', and 'Active'. Below this is a list of cases (1-6) and a table of review data. The table has columns for 'Review Type', 'Meeting Co...', 'Review Date', 'Critiques', and 'Description'. The 'Description' column contains values like 'N', 'TEST', 'teeee', 'nnnnn', and 'aaaaa'. On the right side, there is a summary panel with various statistics:

Report Alerts	13
Export Alerts	2
All Open Patients	28
. Missing Required Fields	19
. Fail Edits	26
. Open Reviews	6
. Open Ticklers	1
Count of All Patients	176
Most Recent Update	731jTb_060509
AIS Version	2005
Rebuild Open List	Click Here

A red arrow points to the 'Open Reviews' value of 6 in the summary panel.

4. Open Ticklers. If there is not a closing date (REMINDER_COMPLETE) for every Tickler entered on this Patient, they will be counted on this line. Ticklers are usually started on the patients main data entry screen and completed there or within the PIPS screen.



C. System and Patient Count Information.

1. Count of All Patients displays the total number of Patients in your Database
2. Most Recent Update displays the name of the last update run on the system. To see the list of ALL updates that have been run on your system, click on Help>>About from your Main Menu.
3. AIS Version displays the AIS update level of your system.

D. Rebuild Open List:

The program will create your original Open List based on All Patients in your database with a hospital arrival date. You may want the program to select Patients only from the last several months, for example. If this is the case, you can create a new Open List based on a specific date range by clicking this option. The open list normally automatically updates itself, but if it does not, 'rebuild' will update all the lists on the 'System Information' button described above.

Notice: The List Rebuilding process may take a long time. If you have a very large Patients File, it is best to remake your open list for a SHORT time frame, such as the last several months only.

Select by Date Range

Report Name: OK EXIT

Using date field: **HOSPITAL_ARRIVAL_DATE**

Making list: **SELECT_DATE**

Beginning Date:











Ending Date:

Report Alerts	12
Export Alerts	2
All Open Patients	
. Missing Required Fields	29
. Fail Edits	20
. Open Reviews	26
. Open Ticklers	6
	3
Count of All Patients	176
Most Recent Update	731jTb_060509
AIS Version	2005
Rebuild Open List	Click Here

The program will continue to evaluate and count the “Open” Patients for you, based on this list. You do not need to rebuild it again, unless you want to change the date range used for the Patients in the Open List or if you think the count is inaccurate.

System Administrator Tip: By default, the date used to create this list is the Hospital_Arrival_Date. If you prefer to use another date field to create this Open List, you may do so by changing the name of the Date field in the VOC record called REBUILD_OPEN. Contact Support for assistance with this.

Data Entry Short Cut Buttons and Keys - most used are in yellow

Short Cut	Button	Explanation
F1 = Help		Pressing F1 while the cursor is in a field will give you popup help for that specific field. The field name will be written at the top of the popup.
F2 = Options		Pressing F2 while the cursor is in a field will usually display a list of valid codes for the field.
F3 = Zoom		Pressing F3 while the cursor is in a field will display a popup zoomed on the field.
F4 = Edit		Pressing F4 while the cursor is in a field will place that field in edit mode. Once the field is in edit mode you can modify the data in that field.
F5 = TCL		Pressing F5 at any time within the software will display the TCL command window without exiting the current screen.
F8 = Clear Screen		Pressing F8 will clear the screen of data.
F9 = Save		Pressing F9 will save the data entered on a screen.
F10 = Main Menu		Pressing F10 at any time will activate the Main Menu without exiting the current screen.
Alt+F2 = Patterns		Pressing Shift+F2 while the cursor is in a field will take you to the Pattern for that field.
		Move forward and back between data entry screens
Down arrow on Tracking Number		Last name look-up for patient records
		Save the record and close the data entry screen
		Save the record and clear the screen for the next record
		Use to exit a process without saving changes or starting a process
		These buttons appear only when in a field that allows multiple entries. Insert with all a line below the cursor, Delete will delete the line of data you are currently on, and, Add will add a line at the botton of your multiple data.
		Print access to MERGES; a summary/letter on one patients data
QBF – Query By Function allows you to scroll through groups of records for review		
F6 = Previous		Pressing F6 while in the QBF mode will take you to the previous record.
F7 = Next		Pressing F7 while in the QBF mode will take you to the next record.
F11 = Initialize		Pressing F11 while in a file with initialize the QBF mode.
F12 = Execute		Pressing F12 while in QBF mode will execute the query
Shift+F6 = First		Pressing Shift+F6 while in QBF mode will take you to the first record.
Shift+F7 = Last		Pressing Shift+F7 while in QBF mode will take you to the last record.



Test Your Knowledge

Navigating Through the System

Circle the letter to the answer(s) you feel accurately answers the question. There can be more than one correct answer given.

1. **How do you get to the MAIN MENU of your system?**
 - a. Double-click on the registry icon and enter a sign-on/password
 - b. Call the CDM Support Hub
 - c. Press the ESC key

2. **You are ready to begin entering a patient's information into the database. From the MAIN MENU, where do you start?**
 - a. Click on the PATIENTS section at the MAIN MENU and choose the appropriate dataset
 - b. Click on the Green plus sign in the upper left corner of your screen
 - c. Press the ESC key

3. **Where would I find a dropdown menu?**
 - a. By clicking on any section at the MAIN MENU
 - b. Call the CDM Support Hub
 - c. Press the ESC key

4. **What is a function key?**
 - a. A key that gets you into a function/process
 - b. A shortcut to a function/process
 - c. A key with multiple uses

5. **Where would I find a list of function keys?**
 - a. Online manual
 - b. Written manual
 - c. Key template

6. **Where do I find help when I'm not sure what is supposed to be entered in a field?**
 - a. Online manual
 - b. Written manual
 - c. F1 key

7. **How do I delete a patient's record?**
 - a. Open a patient's record and then press the DELETE key
 - b. Open a patient's record and press ALT D
 - c. Call the CDM Support Hub



8. **How do I reset the sequential counter for the patient's TRACKING NUMBER if I have deleted a patient or inadvertently skipped a number?**
 - a. Call the CDM Support desk
 - b. At the MAIN MENU, select PATIENTS, SEQUENTIAL COUNTER and then enter in the last number utilized.
 - c. Within patient data entry, press the F2 key and reset the number within the field

9. **I can use my mouse to point-click on each individual field within a patient's record or I can use the <Enter> key or <Tab> key.**
 - a. True
 - b. False

10. **FIND these commonly used features:**
 - a. Trauma Scoring Calculator
 - b. Provider Credential Information
 - c. Hospital Divert/Bypass information in the FACILITIES file
 - d. PATIENTS dictionary
 - e. System Manual

1: a/b, 2: a/b, 3: a, 4: a/b, 5: a/b/c, 6: a/b/c, 7: b/c, 8: a/b, 9: a

Code Files

Circle the letter to the answer(s) you feel accurately answers the question. There can be more than one correct answer given.

1. **What is the purpose of a code file?**
 - a. To ensure the consistency of the data.
 - b. To avoid duplication of information
 - c. To make data entry easier

2. **How do I add a new physician?**
 - a. At the MAIN MENU, click on CODES, CODE FILES, PROVIDERS
 - b. At the MAIN MENU, click on CODES, PATTERNS, PROVIDERS
 - c. Push <ALT><F2> from the patient data entry field

3. **During data entry how do I know if a field is from a Code File vs. a Pattern vs. a System Pattern?**
 - a. Press the (F2) key and notice at the top of the dialog box, the name of the field appears along with its location of origin
 - b. Press the (F1) key and read the HELP text
 - c. When on the field look at the bottom of the screen



4. **Dr. Jones has moved away to Australia and will not be coming back. You should delete his PROVIDERS CODE file.**
 - a. True
 - b. False

5. **How and when do you delete a CODE in a file?**
 - a. Ctrl- Alt- Delete, when they give notice of resignation
 - b. Alt D, when you've made a typo on his file
 - c. Never

6. **How do you make a CODE in a file inactive?**
 - a. Go into the specific code pattern or file and place the letter N in the field for "Make Active".
 - b. Ignore it when doing data entry
 - c. Call the CDM Support Hub

7. **What are some of the CODE files that change often?**
 - a. Agency, Complications, Counties, Criteria, Facilities, Institute, Nursing Stations, Procedures, Providers
 - b. Area Codes, Category, ETOH, Occupation
 - c. None

8. **How do I know a field has options or CODES to choose when I'm doing data entry?**
 - a. Press the (F2) key on the data entry field
 - b. Left-click the mouse on the data entry field
 - c. Read the toolbar at the bottom of the Window for information
 - d. Look for the pick-list choices – center bottom of the data entry screen

9. **Within the PROVIDERS CODE file I can keep track of his/her certifications?**
 - a. True
 - b. False

10. **Within the PROVIDERS file I can keep track of their mailing addresses for follow-up letters. What other CODE FILES offer this option?**
 - a. Agency and Facilities
 - b. Nursing Stations
 - c. Counties

1: a/b/c, 2: a/c, 3: a, 4: b, 5: c, 6: a/c, 7: a, 8: a/d, 9: a, 10: a

Patterns and System Patterns

Please take a minute to answer the following questions prior to your first scheduled tutor session. Circle the letter to the answer(s) you feel accurately answers the question. There can be more than one correct answer given.

1. **The System Pattern Files change frequently.**
 - a. True
 - b. False
2. **Where would you add a name for a new Abstractor recently hired into your department?**
 - a. From the data entry field push <Alt><F2>
 - b. At the MAIN MENU, select CODES, CODE FILES, PROVIDERS
 - c. At the MAIN MENU, select CODES, PATTERNS, ABTRACTOR
3. **The client should never delete System Patterns.**
 - a. True
 - b. False
4. **You have a new Plastic Surgery service at your hospital. Where would you add that in the system?**
 - a. Code Files Specialties
 - b. Patterns Specialties
 - c. System Patterns Specialties
5. **If you're not sure what steps to take related to PATTERNS or SYSTEM PATTERNS you should.**
 - a. Call the CDM Support Hub for assistance
 - b. Look in your written or online manual
 - c. Just start changing things, what could it hurt?
6. **I still don't know the difference between CODE files and PATTERNS. Will it make a difference in my data entry?**
 - a. No, the difference is internal and important when changing or adding codes.
 - b. Yes, you must fully understand the difference or else you'll be totally lost.

1: b, 2: a/c, 3: a, 4: a, 5: a, 6: a



Filters and List Making

Circle the letter to the answer(s) you feel accurately answers the question. There can be more than one correct answer given.

1. **What is a filter?**
 - a. Another name for a list of records
 - b. A rock group
 - c. A grouping of different fields in the system

2. **Can you create a FILTER based on a period of time?**
 - a. Yes, there is one way to do this, go to the MAIN MENU, FILTERS
 - b. Yes, there are several ways to do this, Wizards, Report Fundamentals and others
 - c. No, it's impossible

3. **What is the importance of a FILTER?**
 - a. It is the basis for most reporting on a subset of patients in your system
 - b. It groups patients according to specific fields (Dates, Providers, Age, ICD9, etc.)

4. **What is a CURRENT DAY FILTER?**
 - a. Creates a list of patients based on today's date
 - b. Creates a list of patients based on yesterday's date
 - c. Creates a list of patients based on a group of dates

5. **You've created a FILTER for the month of DECEMBER and two weeks into the next month, you find a patient's chart that hasn't been entered. That patient came into the hospital December 12th. You enter their record and now the FILTER you created for the month of December is updated with that new patient's tracking number.**
 - a. True
 - b. False

6. **Should you update the ALL.PATIENTS list frequently?**
 - a. Yes, especially when preparing to run a report on the entire database
 - b. No, it does it automatically

7. **When would I EDIT a FILTER?**
 - a. When I've put a patient on a list who doesn't belong
 - b. When I've deleted or added a patient to the database after creating the FILTER
 - c. When the moon is full

8. **How do I EDIT a FILTER?**
 - a. At the MAIN MENU, select FILTERS, EDIT FILTERS, choose the FILTER, and then make the necessary change, SAVE
 - b. At TCL, type EDITLIST and filter name, <Enter> and then make the necessary change, SAVE
 - c. Call the CDM Support Hub

9. What is the one FILTER that should never be deleted?
- a. TEST
 - b. ALL.PATIENTS
 - c. TS
10. If I delete a FILTER I've also deleted the patient's record.
- a. True
 - b. False

1: a 2: b, 3: a, 4: a, 5: b, 6: a, 7: a/b 8: a/b/c 9: b, 10: b

Reports

Circle the letter to the answer(s) you feel accurately answers the question. There can be more than one correct answer given.

1. The report capabilities of the registry are very powerful yet flexible.
- a. True
 - b. False
2. The purpose of the Frequently Used Reports section is:
- a. Easy access to reports that are used on a regular basis
 - b. A separate list of reports you cannot find anywhere else in the system
3. Why does the dropdown menu show the various types of reports as well as a library of reports?
- a. To allow clients to go directly to the type of report they're interested in utilizing
 - b. To allow clients to search reports in various methods
 - c. To confuse the client
4. When might I use a merge?
- a. When wanting to run a report with specific information on an individual patient
 - b. When wanting to run a report with specific information on a small subset of patients
 - c. When wanting to run a report on audit filters, complications, reviews, etc.
5. Is the Report Fundamentals reporting engine similar to the Reporting Wizard?
- a. Yes
 - b. No

6. **A physician comes to you with a request for data. He/she has asked for all the patients they have ever admitted and wants to know how many were men, how many were women, of those how many died and the average time they spent in house as a patient. What is the first step necessary to complete this request?**
 - a. Find out when they need the information
 - b. Clarify the time frame and content of the data being requested
 - c. Create a FILTER (list)

7. **Using the scenario in the above question (#6), what type of report would you generate and give to this physician?**
 - a. Activity
 - b. Descriptive Statistic
 - c. Crosstab

8. **There has been discussion of patients remaining in the Emergency Department too long. Your medical director has asked that you run a report showing him/her the average length of stay in the ED. What type of report would you generate?**
 - a. Activity
 - b. Descriptive Statistic
 - c. Crosstab

9. **Whenever you're asked to create a report, you should ALWAYS start from scratch and build a new report.**
 - a. True
 - b. False

10. **Ninety-nine percent of the time we use what data file to generate a report?**
 - a. PROVIDERS
 - b. PATIENTS
 - c. CODE FILES

1: a, 2: a, 3: a/b, 4: a/c, 5: a, 6: a/b/c, 7: c, 8: b/c, 9: b, 10: b



Additional Take-Home Practice Assignments

1. Locate the online MANUAL within your system.
2. From the MAIN MENU, enter a dummy patient using the PATIENT DATA entry. Make this a patient a female who was involved in a fall and lived during the month of November, 2011
3. Add new physicians to your database.
 - a. Trauma Surgeons – Gregory Cut, MD; James Jefferson, DO
 - b. Neurosurgeons – Steven Spine, MD
4. Add a new pre-hospital agency to your database.
 - a. American Ambulance (Ambulance)
5. Dr. Jefferson moved out of the country, make him inactive.
6. Add a new service to your hospital: Hand/Microvascular Surgery.
7. Add a new specialty to your hospital: Hand/Microvascular.
8. Create a FILTER for patients who were discharged in the month of November 2011.
9. Create a FILTER for the patients in the 4th quarter of 2011.
10. Create a FILTER for all the patients in the database.
11. Create a FILTER for the patients discharged in the month of December 2011.
12. Create a FILTER of all the patients who died, save it as DEAD.
13. Rename the DEAD filter to DEATHS.
14. Using the FILTER you created for patient's d/c in December 2011, run the frequently used SUMMARY report.
15. Create a report that will show only the average length of stay in the Emergency Department.
16. Dr. Legg wants a report of just the patients he admitted. On this report he wants to see the patient's name, arrival date, cause of injury, outcome, length of stay and injury severity score.
17. There is only one person (YOU) responsible for data collection, data abstraction and data entry. Therefore, you really don't want or need to keep track of the abstracting information. Take the ABTRACTOR field completely off the screen.
18. Change the order of the screens so that the Discharge Data comes just before the Charges.



19. Set the admission type to default to E for emergency.
20. Make the category field required with data entry.
21. Find the appropriate section for exporting data to your Region or State, be prepared to explain the process.

Frequently Asked Questions

1. Why is the calculator not available for a specific patient during data entry?

The calculator is a teaching aid designed to educate new users to the components of the Probability of Survival calculations done during data entry. To get to this choose 'View' from the Main Menu.

2. How can you select from the pop-up list without using the old <F2> key and without using the mouse?

On the pop-up list try using your 'enter' key to select and your 'enter' key to save and return to the data entry window.

3. How do I look up patients using the .LOOK UP from the TRACKING_NO field?

Yes. The '.LOOK UP' works off an index for the medical record number. To try this function go to the first field on the data entry screen and type in a period and the medical record number you are looking for. For example if the patient's medical record number was 123 you would type in .123 and enter. A list of all patients with this number will pop-up.

4. When entering data into the admitting service field I get an error with the SYSPATTERN for ADM_SVC. Is there a problem with the validation?

The validation of new codes added to patterns only occurs if in the 'Custom' features of the pattern specifies a 'Special Validation'. Most patterns do not use this feature, but ADM.SVC does. If a pattern does use the validation feature it means that it will be double-checking codes that have been entered into a pattern against some other file such as specialties. The actual validation check does not occur as you add codes to a pattern, instead this occurs during actual patient data entry

5. Is it possible to edit data in a text field that has a default (e.g. Diagnoses) without everything in the field automatically erasing when I type?

Use your <F4> to toggle the edit mode for a field. <F3> opens the ZOOM to look at and edit large text fields.

6. Can I make new question codes & answers?

Yes, from the Code Groups file. Here you are able to identify the field, the file and the choices for questions. For example if we want several additional questions to come up when a patient has an outcome of 'D' you can set this up in the Code Group file under the Codes menu.

You would go to Code Group file and as the 'Code' you would enter in 'OUTCOME.D'. This naming convention takes the field/file and the actual code or entry choice you want the group of questions associated with. In this case OUTCOME is the field and 'D' is the data entry code. From here you can fill in as many questions as you want with pre-specified answers in the 'Group' screen. Check this out on the data entry screen for Code Groups, look for 'OUTCOME.D' and page through the screens to see how this is set up. Also look at the 'CAUSE_CODE.GSW'. To see them in action try data entry into the 'Discharge Outcome' field on the Discharge Data screen and enter a 'D', also go to the 'Cause Code' field on the Event Data screen and enter in 'GSW'.

7. Can the order of the vital sign fields be changed?

Yes, all screens that pop-up fields such as vital signs, risk code fields, transport data, scene procedures, nursing station data, ED vitals, Scene vitals, Referring vitals, provider data all can be easily customized. These screens work off of the 'Code Group' file. You can remove/add fields, change fields or code orders. This allows the user tremendous power when adjusting the system to meet their needs. To see how these are set up and how you could make changes go to the 'Codes' menu and select 'Code Groups'. From here, take a look at the following examples being used in the system now (page through each of the screens):

CHARGE_CODE
COMP_GROUP
SCENE_PROCEDURES
REF_VITALS

8. How do you switch the order of screens?

To adjust the order of the data entry screens you will need to alter the 'PATIENTS_DATA' control group. To get to this function from the main menu select 'Tools' and click on 'Controls'. From the list double click on 'PATIENTS_DATA' and click on the 'Dialogs' tab across the top. You will see a list of the screens you now see during data entry. To reorder these screens left click on the column 'LABEL' and you will have the option to reorder your data entry screens.

You can also turn off the screen within the code group if you don't want the data fields at all.

Once you are done with these changes simply save the record and the change takes effect.

9. What do the asterisk (*) next to my data entry fields mean?

Based on the account control used for called CHECK_FIELDS. These fields should not be removed or disabled on your data entry screens because they most likely are part of requirements within your state/region or NTDS data-set.

10. If I need assistance, how do I reach CDM support?

The CDM Technical Support Hub will be happy to take your call. They can be reached at (303) 670-3331 extension 2. In addition you can fax support with screen shots and detail (303) 670-3394, or email support@c-d-m.com

11. Can I still see my edits even if I turn off the auto-edit that occurs when I save a patient record?

Yes! On the data entry screen you will see a button labeled 'All Active Edit's'. Click here at any time during data entry to see edits on your patients.

12. Does the system keep copies of my patient records that I can look at and restore? Yes. The system keeps mirror records of each patient at the time they are saved. These can be accessed by clicking on the button on the data entry screen labeled 'Compare Records'.

Data Dictionary

ROAD-MAP FOR GENERAL PATIENT_DATA (3/2012) NOTE: YELLOW HIGHLIGHT IS FOR NTDS 2012 FIELDS				
SCREEN FOLDER	CODE GROUP	FIELD SCREEN LABEL	FIELD NAME	FIELD DESCRIPTION
On Screen		Tracking Number	TRACKING_NO	This is the patient's Tracking Number.
On Screen		Institute Number	INSTITUTE_NO	This is the institution number for the hospital.
Ticklers!	REMINDER_GROUP	Date	REMINDER_DATE	This is the date of the Reminder.
		Comments	REMINDER_COMMENTS	This is comments regarding the reminder.
		Initials	REMINDER_PROVIDER	This is the code to whom the reminder applies.
		Completed (Yes or No)?	REMINDER_COMPLETE	This is whether the reminder has been completed.
Record Entry	ENTRY_GROUP	D.E. Initials	RECORDER	This is the person who recorded the case.
		Admit Num	NUM_ADMISSIONS	This is the number of this admission in relation to previous hospitalizations.
		Abstractor	ABSTRACTOR	This is the name of the person who abstracted this patient.
		Abstract	ABSTRACT	This is the status of the abstract.
		Abstract Date	ABSTRACT_DATE	This is the date this patient was abstracted.
		Date Received	DATE_RECEIVED	This is the date the record was received.
		Which AIS version is used?	SEVERITY_METHOD	This is the severity coding methodology.
		Injury Time	INJURY_TIME	This is the time of injury.
		Injury Date Hospital	INJURY_DATE	This is the date of the injury.
		Arrival Time Hospital	HOSPITAL_ARRIVAL_TIME	This is the time the patient arrived at the hospital.
		Arrival Date Transport Mode to Your Hospital	HOSPITAL_ARRIVAL_DATE	This is the date the patient arrived at the hospital.
			TRANS	This is the transport code.
Hospital Data	HOSPITAL_GROUP	Hospital Arrival Time	HOSPITAL_ARRIVAL_TIME	This is the time the patient arrived at the hospital.
		Hospital Arrival Date	HOSPITAL_ARRIVAL_DATE	This is the date the patient arrived at the hospital.
		Transport Mode	TRANS	This is the transport code.
		Other Transport Modes	TRANS_OTHER	These are other types of transports that were used for this patient.
		Admit Service	ADM_SVC	This is the service the patient was admitted to.
		Admit Type	ADMIT_TYPE	This is the admit type.
		Admitting Diagnosis	ADMITTING_DX	This is the admitting diagnosis.
		Trauma Team	TEAM_NOTIFIED	This is whether the trauma team was notified or not.
		Team Activated by	TEAM_ACTIVATED_BY	This is who activated the trauma team.
		Team Level	TEAM_LEVEL	This is the level of team activation.
		Team Notified Time	TEAM_NOTIFIED_TIME	These are the times of trauma team notifications.
		ED Admission Time	ED_ADM_TIME	This is the ED Admission time.
		ED Admission Date	ED_ADM_DATE	This is the ED Admission date.
		ED Discharge Time	ED_DC_TIME	This is the ED discharge time.
		ED DC Date	ED_DC_DATE	This is the ED discharge date.
		ED Disposition Code	ED_DISPOSITION_CODE	Entered ED Disposition Code.
		Time in ED	ER_TIME	This is the time the patient spent in the ER.
				This is the condition of the patient on arrival to the hospital. May refer to 'whether there were signs of life present'.
		Signs of Life at Arrival	ARRIVAL_CONDITION	
		Final Outcome of Patient	OUTCOME	This is the patient's outcome: 'A' or 'D'.
Demographic Data	DEMOGRAPHIC_GROUP	Med Rec Num	MEDICAL_RECORD_NUMBER	This is the medical record number for the patient.
		Social Security	SOCIAL_SECURITY_NUMBER	This is the patient's social security number.
		Patient Number	PATIENT_NUMBER	This is the patient number.
		Last Name	NAME_LAST	This is the last name of the patient.
		First Name	NAME_FIRST	This is the patient's first name.
		M.I.	NAME_MI	This is the patient's middle name or initial.
		Address	ADDRESS	This is the address, city, and state for the patient.
		Zip Code	ZIP_CODE	This is the patient's Zip Code.
		City	RES_CITY	This is the city of residence.
		County	RES_COUNTY_STATE	This is the code for residence county or state.
		State	RES_STATE	This is the state of residence.
		Country	COUNTRY	This is the country of residence.
		Alt. Home	HOME	This is a description of the patient's home situation.
		Area Code	AREA_CODE	This is the patient's area code.
		Phone	PHONE	This is the patient's phone number.
		Race	RACE	This is the patient's race.
		Other Race	RACE_OTHER	This is the other (secondary) race designation for this patient.
		Ethnicity	ETHNICITY	This is the ethnicity of the patient. It is different from the RACE.
		Sex	SEX	This is the patient's sex or gender.
		Marital Status	MARITAL_STATUS	This is the patient's marital status.
		DOB	DOB	This is the patients date of birth.
				If < 3 wks: this is days; < 3 months: weeks; < 3 yrs: months; years otherwise.
		Age	AGE_NUMBER	This is the unit of age: 'D' for days, 'W' for weeks, 'M' for months or 'Y' for years.
		Units	AGE_UNITS	
Event Data	EVENT_GROUP	Incident No	INCIDENT_NO	This is the incident (crash) number.
		Cause Code	CAUSE_CODE	This is the cause code. Refer to the CAUSE file.
		Work Related	INDUST_ACC	This is whether the accident is an industrial accident or not.
		Occupation	OCCUPATION	This is the patient's occupation.



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		Industry	INDUSTRY_TYPE	This is the type of classification of the industry in which the patient is employed.
		Trauma Type	TRAUMA_TYPE	This is the type of the dominant injury.
		Details	INJURY_DETAILS	This is detail of the injury.
		Extrication	EXTRICATION	This is whether extrication was performed.
		ECode Location	LOCATION	This is the ICD9 'E' geographic location code. Refer to LOCATIONS file.
		Exact Location	LOCALE	This is a text description of the location of the accident or injury.
		Zip Code	INJURY_ZIP	This is the zip code of the location where the injury occurred.
		County where injury occurred	COUNTY_STATE	This is the county or state code.
		Nearest Town	NEAREST_TOWN	This is the town nearest to the injury.
		State	INJURY_ST	This is the state where the injury occurred.
		Country	INJURY_COUNTRY	This is the country of injury.
		Child Restraint	CHILD_RESTRAINT	This is the type of child restraint used (NTDS07).
		If Airbag was a Protective Device, Airbag Type	AIRBAG	This is the type of airbag deployed (NTDS07).
E Codes Group	EVENT_ECOCODES_GROUP	E Codes	CAUSE_E_CODES	These are the ICD9 E codes for cause. 'E' is not required.
		Description	CAUSE_E_CODES_DESC	Description of this E Code.
Protective Devices Group	EVENT_PROTECTIVE_DEVICE	Protective Devices	PROTECTIVE_DEVICES	These are the protections used, such as seat belt, car seat, etc.
Triage Data	TRIAGE_GROUP	Code	TRIAGE_CODES	These are the triage codes.
		Description	TRIAGE_CODES_DESCRIPTION	These are descriptions of the triage codes.
		Identified	TRIAGE_IDENTIFIED	This is who or what identified this triage code or reason.
Risk Data	RISK_GROUP	Code	RISK_TYPE	These are the risk factor codes.
		Description	RISK_FACTOR	These are descriptions of the risk factors.
Transport Data	TRANSPORT_GROUP	Agency	TRANSPORT_AGENCY_CODE	This is the transporting agency code.
		Origin	TRANSPORT_ORIGIN	These are the origins of the transport segments.
		Record No	TRANSPORT_RECORD_NO	This is the patient's transport record number (transport ID number).
		ALS/BLS	TRANSPORT_LEVEL	These are the levels of life support available.
		Trip	TRIP_FORM	This is whether the trip form was completed.
		Notify Time	NOTIFY_TIME	These are the times the agencies were notified.
		Notify Date	NOTIFY_DATE	These are the dates the agencies were notified.
		Arrival Time	ARRIVAL_TIME	These are the times of arrival on the scene.
		Arrival Date	ARRIVAL_DATE	These are the scene arrival dates.
		Depart Time	DEPARTURE_TIME	These are the times the agencies departed from the scene.
		Depart Date	DEPARTURE_DATE	These are the dates the agencies departed from the scene.
		Destination	TRANSPORT_DESTINATION	These are the transport destinations.
		Explanation	TRANSPORT_DELAY	These are reasons for a delay in transportation.
Scene Vital Signs	VITALS10	Pulse	PULSE	These are the pulse rates.
		Resp Rate	RESP_RATE	These are the respiratory rates.
		Sys BP	SYS_BP	These are the systolic blood pressures.
		Dias BP	DIAS_BP	These are the diastolic blood pressures; 'D' = doppler or 'P' = palpated.
		GCS Eye Opening	EYE_OPENING	These are the GCS eye openings: 1 = none, 2 = pain, 3 = voice or 4 = spontaneous.
		GCS Verb Response	VERBAL_RESPONSE	These are GCS verbal responses: 1= none, 2= incomp, 3= inapp, 4= confused, 5= oriented.
		GCS Motor Response	MOTOR_RESPONSE	These are the GCS motor values: 1= none, 2= ext, 3= flex, 4= withd, 5= local, 6= obey.
		GCS Total	GLASGOW	These are the Glasgow Coma Scores that are filled if the components are not available.
		TS Intub	INTUBATED	These are whether the patient was intubated when Trauma Score was done.
		Paralytics	PARALYTICS	Were paralytic agencies given prior to GCS
		Oxygen Saturation	OXIMETRY	This is the percent blood Oxygen saturation.
		VS Time	VS_TIME	These are the times the vital signs were measured.
		VS Date	VS_DATE	These are the dates the vital signs were measured.
		VS Number	VS_NUMBER	Vital Sign numbers: scene (1), ER (2), One-Hour (3). Decimals are extra scores.
		VS Loc Code	VS_LOCATION_CODE	These are where the Vital Signs were measured.
ED Vital Signs	VITALS20	Pulse	PULSE	These are the pulse rates.
		Resp Rate	RESP_RATE	These are the respiratory rates.
		Sys BP	SYS_BP	These are the systolic blood pressures.
		Dias BP	DIAS_BP	These are the diastolic blood pressures; 'D' = doppler or 'P' = palpated.
		GCS Eye Opening	EYE_OPENING	These are the GCS eye openings: 1 = none, 2 = pain, 3 = voice or 4 = spontaneous.
		GCS Verb Response	VERBAL_RESPONSE	These are GCS verbal responses: 1= none, 2= incomp, 3= inapp, 4= confused, 5= oriented.
		GCS Motor Response	MOTOR_RESPONSE	These are the GCS motor values: 1= none, 2= ext, 3= flex, 4= withd, 5= local, 6= obey.
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		Oxygen Saturation	OXIMETRY	This is the percent blood Oxygen saturation.
		VS Time	VS_TIME	These are the times the vital signs were measured.
		VS Date	VS_DATE	These are the dates the vital signs were measured.



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		VS Number	VS_NUMBER	Vital Sign numbers: scene (1), ER (2), One-Hour (3). Decimals are extra scores.
		VS Loc Code	VS_LOCATION_CODE	These are where the Vital Signs were measured.
		PTS Air	PTS_AIRWAY	These are the Pediatric Trauma score airway values.
		PTS CNS	PTS_CNS	These are the Pediatric Trauma Score central nervous system values.
		Temps	TEMPS	These are the patient's temperatures.
		Weights in Kg	WEIGHTS	These are the weights of the patient.
		Respiratory Assistance	ASSISTING	This is the type of respiratory assistance.
		Supplemental Oxygen	VS_O2	This is the amount of oxygen administered.
Full Vitals Table	VITALS_GROUP	Pulse	PULSE	These are the pulse rates.
		Resp Rate	RESP_RATE	These are the respiratory rates.
		Sys BP	SYS_BP	These are the systolic blood pressures.
		Dias BP	DIAS_BP	These are the diastolic blood pressures; 'D' = doppler or 'P' = palpated.
		GCS Eye	EYE_OPENING	These are the GCS eye openings: 1 = none, 2 = pain, 3 = voice or 4 = spontaneous.
		GCS Verbal	VERBAL_RESPONSE	These are GCS verbal responses: 1 = none, 2 = incomp, 3 = inapp, 4 = confused, 5 = oriented.
		GCS Motor	MOTOR_RESPONSE	These are the GCS motor values: 1 = none, 2 = ext, 3 = flex, 4 = withd, 5 = local, 6 = obey.
		GCS Total	GLASGOW	These are the Glasgow Coma Scores that are filled if the components are not available.
		Paralytics	PARALYTICS	Were paralytic agencies given prior to GCS
		Oxygen Saturation	OXIMETRY	This is the percent blood Oxygen saturation.
		Time	VS_TIME	These are the times the vital signs were measured.
		Date	VS_DATE	These are the dates the vital signs were measured.
		Number	VS_NUMBER	Vital Sign numbers: scene (1), ER (2), One-Hour (3). Decimals are extra scores.
		Location	VS_LOCATION_CODE	These are where the Vital Signs were measured.
		Temp	TEMPS	These are the patient's temperatures.
		Respiratory Assistance	ASSISTING	This is the type of respiratory assistance.
		Supplemental Oxygen	VS_O2	This is the amount of oxygen administered.
Transfer Information	HOSPITAL_BYPASS_GROUP	Was the Patient transferred from another Facility?	HOSPITAL_TRANSFER	This is whether the patient was transferred from another facility: Y (yes), N (no).
		Bypass	HOSPITAL_BYPASS	This is if another hospital was bypassed: Y (Yes), N (No), NA (Not Applic).
		Divert	ON_BYPASS	This is whether the hospital was on divert at the time the patient arrived.
		Divert Reason	BYPASS_EXPLANATION	This is an explanation of the bypass situation.
Referring Facility	REFERRING_GROUP	Referring Facility Code	FROM_HOSPITAL	This is the facility from which the patient transferred.
		Referring Provider	REFERRING_PROVIDER	This is the provider referring the patient.
		Referring Arrival Time	REFERRING_ARRIVAL_TIME	This is the time the patient arrived at the referring hospital.
		Referring Arrival Date	REFERRING_ARRIVAL_DATE	This is the date the patient arrived at the referring hospital.
		Referring Discharge Time	REFERRING_DISCHARGE_TIME	This is the time the patient was discharged from the referring hospital.
		Referring Discharge Date	REFERRING_DISCHARGE_DATE	This is the date the patient was discharged from the referring hospital.
Was Patient Transferred?	HOSPITAL_TRANSFER.Y	Referring Facility Code	FROM_HOSPITAL	This is the facility from which the patient transferred.
		Referring Arrival Time	REFERRING_ARRIVAL_TIME	This is the time the patient arrived at the referring hospital.
		Referring Arrival Date	REFERRING_ARRIVAL_DATE	This is the date the patient arrived at the referring hospital.
		Referring Discharge Time	REFERRING_DISCHARGE_TIME	This is the time the patient was discharged from the referring hospital.
		Referring Discharge Date	REFERRING_DISCHARGE_DATE	This is the date the patient was discharged from the referring hospital.
		Transfer Mode	TRANSFER_MODE	This is the mode of the transfer from the referring facility.
		Referring Admit Type	REFERRING_ADMIT_TYPE	This is the admit type at the referring facility.
		Tr Surg Consult	REFERRING_CONSULT	This is whether the patient had a Trauma Service consult at the referring hospital.
		Referring Consult Time	REFERRING_CONSULT_TIME	This is the time of the Trauma Service consult at the referring hospital.
		Referring Consult Date	REFERRING_CONSULT_DATE	This is the date of the Trauma Service consult at the referring hospital.
Inpatient Units	UNIT_GROUP	Unit	UNIT_CODE	These are the codes for the nursing units.
		Admit Time	UNIT_ADMIT_TIME	These are the times the patient was admitted to the nursing units.
		Admit Date	UNIT_ADMIT_DATE	These are the dates the patient was admitted to the nursing units.
		DC Time	UNIT_DC_TIME	These are the times the patient was discharged from the nursing units.
		DC Date	UNIT_DC_DATE	These are the dates the patient was discharged from the nursing units.
		Disposition	UNIT_DISPOSITION_CODE	These are the unit disposition codes.
Discharge	DISCHARGE_GROUP	Outcome	OUTCOME	This is the patient's outcome: 'A' or 'D'.
		Inpatient Discharge Time	DISCHARGE_TIME	This is the hospital discharge time.
		Inpatient Discharge Date	DISCHARGE_DATE	This is the hospital discharge date.
		Inpatient Disposition Code	DC_DISPOSITION_CODE	This is the DC disposition code.
		Inpatient Transfer To Facility	DC_DESTINATION_CODE	This is the discharge destination code, usually a FACILITIES code.
		Total LOS	LOS	This is the patient's LOS (length of stay) in days.
		Total ICU LOS	TOTAL_DAYS_ICU	This is the total number of days spent in ICU units.
		Vent Days	VENTDAYS	The number of days on a ventilator.
		DC Status	DC_FEED	This is the DC Status code for Feeding.
		DC Status	DC_LOC	This is the DC Status code for Locomotion.
		DC Status	DC_EXP	This is the DC Status code for Expression.
		Comments	COMMENTS	General comments.
Providers	PROVIDERS_GROUP	Code	PROVIDERS_CODE	These are the codes for the providers on the case.
		Type	PROVIDERS_TYPE	These are the types or specialties of the providers caring for the patient.
		Call	MD_CALL_TYPE	These are types of calls placed to the MDs.
		Notify Time	MD_NOTIFY_TIME	These are the times the physicians were notified.



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		Notify Date	MD_NOTIFY_DATE	These are the dates the physicians were notified.
		Reply Time	TIME_REPLIED	These are the times the physicians replied to the calls.
		Reply Date	DATE_REPLIED	These are the dates the physicians replied to the calls.
		Arrival Time	MD_ARRIVAL_TIME	These are the times the physicians arrived.
		Arrival Date	MD_ARRIVAL_DATE	These are the dates the physicians arrived.
		Response	PROVIDERS_RESPONSE	This is the providers response time in minutes.
Diagnoses	DIAGNOSES_GROUP	ICD9	ICD9	These are the diagnosis ICD9 codes.
		Text	DIAGNOSES	These are the anatomic diagnoses.
		Known	DX_KNOWN	How dx were known: S(urgery), A(utopsy), CT(scan), X(ray), E(xamination), or H(istory).
		AIS Code	AIS_CODE	These are the full AIS (Abbreviated Injury Scale) values.
		Region	REGION	These are the regions of injury.
		AIS	AIS	These are the AIS (Abbreviated Injury Scale) values.
ISS	ISS_GROUP	ISS	ISS	This is the Injury Severity Score.
Procedures	PROCEDURE_GROUP	Code	PROCEDURE_CODE	These are the codes for the procedures.
		Episode	PROCEDURE_EPISODE	This is the episode indicator for the procedure.
		Location	PROCEDURE_LOCATION_CODE	These are where the procedure was performed.
		ICD9	PROCEDURE_ICD9	These are the ICD 9 codes for the procedures.
		Detail	PROCEDURE_DETAIL	These are descriptions of the procedures.
		Result	PROCEDURE_RESULT	These are the procedure results.
		Provider	PROCEDURE_PROVIDERS	These are the provider codes for the procedures.
		Proc Start Time	PROCEDURE_START_TIME	These are the times the procedures were started.
		Proc Start Date	PROCEDURE_START_DATE	These are the dates the procedures were started.
		Proc Stop Time	PROCEDURE_STOP_TIME	These are the times the procedures were stopped.
		Proc Stop Date	PROCEDURE_STOP_DATE	These are the dates the procedures were stopped.
Etoh	CLINICAL_GROUP	Blood Type	BLOOD_TYPE	This is the patient's blood type: OPOS (O+), ONEG (O-), etc, and UNK (unknown)
		ETOH (Blood Alcohol)	ETOH	This is the value of the blood alcohol.
		ETOH Tested	EV	This is whether ETOH was evident in the patient: 'Y' for yes or 'N' for no.
		TOX Tested	TOX_TEST	This is whether Toxicology was tested.
Tox Group	TOX_GROUP	Drug Screen Results	TOX	This is the toxicology (drug screen) results. Separate with a comma (for lab compatibility).
Labs	LAB_GROUP	Lab Code	LAB_CODE	These are the lab codes.
		Done In	LAB_LOCATION_CODE	These are the patient's locations when the lab tests were done (NURSING.STATION file).
		Order Time	LAB_TIME	These are the times the lab tests were performed.
		Order Date	LAB_DATE	These are the dates the lab tests were performed.
		Result Time	LAB_RESULT_TIME	This is the time the lab result was received.
		Value	LAB_VALUE	These are the lab values.
		Method	LAB_METHOD	This is the method by which the lab test was performed.
Medications	MEDICATIONS_GROUP	Drug	MED_CODE	These are the medications that were given.
		Provider	MED_PROVIDERS	These are the codes of the physicians that ordered medications.
		Location	MED_LOCATION_CODE	These are where the medications were given.
		Time	MED_START_TIME	These are the times the medications were started.
		Date	MED_START_DATE	These are the dates the medications were started.
Fluids	FLUIDS_GROUP	Fluids	FLUIDS_TYPE	These are the fluid codes. Refer to FLUIDS file.
		Amount	FLUIDS_AMOUNT	These are the amounts of the fluids.
		Details	FLUIDS_DETAILS	These are details of the fluids.
		Location	FLUIDS_LOCATION_CODE	These are where the fluids were given. Refer to NURSING.STATION file.
		Start Time	FLUIDS_START_TIME	These are the times the fluids were started.
		Start Date	FLUIDS_START_DATE	These are the dates the fluids were started.
		Stop Time	FLUIDS_STOP_TIME	These are the stop time of the fluids.
		Stop Date	FLUIDS_STOP_DATE	These are the stop dates of the fluids.
Eligibility	ELIGIBILITY_GROUP	Study Eligibility	ELIGIBILITY	These are the studies for which the patient is eligible.
Findings	FINDINGS_GROUP	Finding	FINDING_CODE	These are the codes for the types of finding.
		Value	FINDING_VALUE	These are the values of the findings.
		Number	FINDING_NUMBER	These are the numbers that identify the finding group.
		Status	FINDING_STATUS	This is the status of the finding: was it present or not?
Complications	COMP_GROUP	Complication	COMP_TYPE	These are the complication codes.
		Comp Occur	COMP_OCCUR	This is the occurrence of this complication. It is used to differentiate multiple occurrences of the same complication code.
		Description	COMP	These are descriptions of the complication codes.
		Location	COMP_LOCATION_CODE	These are where the complications occurred. Refer to NURSING.STATION file.
		Date	COMP_DATE	These are the dates the complications occurred or were discovered.
Critiques	CRITIQUE_GROUP	Critique	CRITIQUE_CODE	These are the critique codes.
		Occurrence	CRITIQUE_OCCUR	This indicates which occurrence. If a critique occurs more than once in a patient the subsequent occurrences can be identified with an occurrence number.
		Description	CRITIQUE_DESCRIPTION	These are descriptions of the critiques.
		Date Occurred	CRITIQUE_DATE	This is the date the critique was identified.
		Responsible Party	CRITIQUE_RESP	This is the provider responsible.
		Location	CRITIQUE_LOC_CODE	These are where the critiques occurred.
		How Identified	CRITIQUE_ID	This is how or who identified the critique.
		Review Date	CRITIQUE_IDENTIFIED	This is the date the critique was first identified.
Reviews (TB)	REVIEW_GROUP	Issue	REVIEW_TOPIC	This is the topic (a critique code) for this review.



CLINICAL DATA[®]

MANAGEMENT

		Occurrence	REVIEW_OCCUR	This indicates which occurrence. If a review occurs more than once in a patient the subsequent occurrences can be identified with an occurrence number.
		Topic Description	REVIEW_TOPIC_DESCRIPTION	This is the topic description.
		Review Type	REVIEW_TYPE	This is the type of review performed.
		Review Date	REVIEW_DATE	This is the date the review was performed.
		Review Discussion	REVIEW_DISCUSSION	This is a general text field for review-specific discussion.
		Action	REVIEW_ACTION	This is the action resulting from the review.
		Physician Reviewer	REVIEWER	These are codes for the reviewers.
		Staff Reviewer	REVIEW_STAFF	Indicates staff members involved in this review (ie, as recorders or abstractors).
		Preventable	REVIEW_PREVENTABLE	This is the preventability assessment for this review.
		Issue Completed	REVIEW_RESOLVE	This is the date this review was resolved.
Reviews (MB)	REVIEW_GROUP_MB	Review Topic	REVIEW_TOPIC	This is the topic (a critique code) for this review.
		Occurrence	REVIEW_OCCUR	This indicates which occurrence. If a review occurs more than once in a patient the subsequent occurrences can be identified with an occurrence number.
		Topic Description	REVIEW_TOPIC_DESCRIPTION	This is the topic description.
		Review Type	REVIEW_TYPE	This is the type of review performed.
		Review Date	REVIEW_DATE	This is the date the review was performed.
		Discussion	REVIEW_DISCUSSION	This is a general text field for review-specific discussion.
		Action Taken	REVIEW_ACTION	This is the action resulting from the review.
		Reviewer	REVIEWER	These are codes for the reviewers.
		Review Completed	REVIEW_RESOLVE	This is the date this review was resolved.
		Alternate Topics	REVIEW_CRITIQUE	This is the critique code assigned to this review. Used in MB when creating a unified Critique and Review group.
		Meeting	REVIEW_MEETING	This is the Meetings ID for this review.
		Next Review Type	REVIEW_NEXT_TYPE	This is the next type of review.
Reviews (TB Multi)	REVIEW_GROUP_TB3	Issue	REVIEW_TOPIC	This is the topic (a critique code) for this review.
		Occurrence	REVIEW_OCCUR	This indicates which occurrence. If a review occurs more than once in a patient the subsequent occurrences can be identified with an occurrence number.
		Topic Description	REVIEW_TOPIC_DESCRIPTION	This is the topic description.
		Review 1	REVIEW_TYPE	This is the type of review performed.
		Review Date 1	REVIEW_DATE	This is the date the review was performed.
		Review Discussion 1	REVIEW_DISCUSSION	This is a general text field for review-specific discussion.
		Action 1	REVIEW_ACTION	This is the action resulting from the review.
		Physician Reviewer	REVIEWER	These are codes for the reviewers.
		Staff Reviewer	REVIEW_STAFF	Indicates staff members involved in this review (ie, as recorders or abstractors).
		Preventable	REVIEW_PREVENTABLE	This is the preventability assessment for this review.
		Issue Completed	REVIEW_RESOLVE	This is the date this review was resolved.
		Review 2	REVIEW_TYPE2	This is the second type for this review.
		Review Date 2	REVIEW_DATE2	This is the second date for this review.
		Review Discussion 2	REVIEW_DISCUSSION2	This is a general text field for review-specific discussion.
		Action 2	REVIEW_ACTION2	This is the second action for this review.
		Review 3	REVIEW_TYPE3	This is the third type for this review.
		Review Date 3	REVIEW_DATE3	This is the third date for this review.
		Review Discussion 3	REVIEW_DISCUSSION3	This is a general text field for review-specific discussion.
		Action 3	REVIEW_ACTION3	This is the third action for this review.
Payments	PAYMENT_GROUP	Payment Source	PAYMENT_SOURCE	These are the payment sources.
		Collected	PAYORS_COLLECTED	These are the amounts collected from each payor.
Charge Data	CHARGE_DATA_GROUP	Charge Total	CHARGE_TOTAL	This is the filled field for TOTAL.CHARGE.
		Amt Collected	AMT_COLLECTED	Addition financial field for amount collected.
		Comments	CHARGE_COMMENTS	These are comments regarding the charges or payments.
Patient Alive	OUTCOME.A	DC Status	DC_FEED	This is the DC Status code for Feeding.
		DC Status	DC_FEED	This is the DC Status code for Feeding.
		DC Status	DC_LOC	This is the DC Status code for Locomotion.
		DC Status	DC_LOC	This is the DC Status code for Locomotion.
		DC Status	DC_EXP	This is the DC Status code for Expression.
		DC Status	DC_EXP	This is the DC Status code for Expression.
Death Data	DEATH_GROUP	Death Preventable?	PREVENTABLE	This is the preventability: Y (Yes), N (No), P (Possibly), NA (Not Apply), U (Unknown).
		DOA	DOA	This is whether the patient was DOA.
		Autopsy/Charted	AUTOPSY	This is the autopsy code. YY: done, charted; YN: done, uncharted; N: not done.
		Autopsy Status	AUTOPSY_STATUS	This is the status of the autopsy, ie: JCAHO codes.
		Autopsy ID	AUTOPSY_ID_NO	This is the autopsy report identification number.
		Organs Req./Granted	DONATION_STATUS	This is the code for organ donations requested, granted, done.
		Cause of Death	CAUSE_DEATH	This is a description of the cause of death.
		Place of Death	PLACE_DEATH	This is where the death occurred.
		Death Time	DEATH_TIME	This is the time of death.
		Death Date	DEATH_DATE	This is the date of death.
Patient Died	OUTCOME.D	Preventable?	PREVENTABLE	This is the preventability: Y (Yes), N (No), P (Possibly), NA (Not Apply), U (Unknown).

		Preventable?	PREVENTABLE	This is the preventability: Y (Yes), N (No), P (Possibly), NA (Not Apply), U (Unknown).
		DOA	DOA	This is whether the patient was DOA.
		DOA	DOA	This is whether the patient was DOA.
		Autopsy Charted	AUTOPSY	This is the autopsy code. YY: done, charted; YN: done, uncharted; N: not done.
		Autopsy Charted	AUTOPSY	This is the autopsy code. YY: done, charted; YN: done, uncharted; N: not done.
		Organs Requested/Granted	DONATION_STATUS	This is the code for organ donations requested, granted, done.
		Organs Requested/Granted	DONATION_STATUS	This is the code for organ donations requested, granted, done.
		Cause of Death	CAUSE_DEATH	This is a description of the cause of death.
		Cause of Death	CAUSE_DEATH	This is a description of the cause of death.
		Death Time	DEATH_TIME	This is the time of death.
		Death Time	DEATH_TIME	This is the time of death.
		Death Date	DEATH_DATE	This is the date of death.
		Death Date	DEATH_DATE	This is the date of death.
		Organs Donated	ORGANS_DONATED	These are the organs that were donated by the patient.
		Organs Donated	ORGANS_DONATED	These are the organs that were donated by the patient.
Organs Donated Group	DEATH_ORGANS_DONATED	Organs Donated	ORGANS_DONATED	These are the organs that were donated by the patient.
TQIP	TQIP_GROUP	TQIP Traumatic Brain Injury <F1 for Help>	TQIP_TBI_PROMPT	TQIP Traumatic Brain Injury Prompt
		TQIP VTE Prophylaxis <F1 for Help>	TQIP_VTE_PROMPT	TQIP VTE Prophylaxis Prompt
GSW Information	CAUSE_CODE.GSW	Team	TEAM_MEMBERS	This are the trauma team members.
		Type	TEAM_MEMBERS_TYPE	This are the trauma team members' type.

FIELDS USED (UPDATED 3/2012)

FIELDS-USED: ALPHABETIC FIELD LISTING (UPDATED 3/2012)

Alphabetic Field Listing	Field Description
ABSTRACT	This is the status of the abstract.
ABTRACTOR	This is the name of the person who abstracted this patient.
ABSTRACT_COMPLETE	This is whether there are any empty fields on this screen.
ABSTRACT_DATE	This is the date this patient was abstracted.
ADDRESS	This is the address, city, and state for the patient. This calculates the hospital admission date based on the Nursing Stations. If unable to determine admission date this way, the field HOSPITAL.ADMISSION.DATE will
ADMISSION_DATE	This calculates the hospital admission time.
ADMISSION_TIME	This displays the last name of the admitting MD.
ADMITTING	This is the admitting diagnosis.
ADMITTING_DX	This displays the name and title of the admitting MD
ADMITTING_NAME	This is the condition on admission.
ADMIT_CONDITION	This is the reason for admission (chief complaint).
ADMIT_REASON	These are the FINDINGS codes associated with the Admission.
ADMIT_REVIEW	This is the admit type.
ADMIT_TYPE	This displays the code of the admitting MD.
ADM_MD_CODE	This is the service the patient was admitted to.
ADM_SVC	This is the description of the ADM.SVC from the Specialties file.
ADM_SVC_DESCRIPTION	This is the state report code from the ADM_SVC field.
ADM_SVC_SRC	This calculates the patient's age in years and hundredths.
AGE	NTDS Age calculation. Date of Birth to hospital arrival in decimal years.
AGE_NTDS	If < 3 wks: this is days; < 3 months: weeks; < 3 yrs: months; years otherwise.
AGE_NUMBER	This is the unit of age: 'D' for days, 'W' for weeks, 'M' for months or 'Y' for years.
AGE_UNITS	This is the NTDS code for AGE_UNITS.
AGE_UNITS_NTDS	This is the type of airbag deployed (NTDS07).
AIRBAG	This is the NTDS code for AIRBAG. Returns null if 'airbag deployed' (NTDS 8) was not found in Protective Devices.
AIRBAG_NTDS	These are the AIS (Abbreviated Injury Scale) values.
AIS	Injury AIS Position 1
AIS1	Injury AIS Position 10
AIS10	Injury AIS Position 2
AIS2	Injury AIS Position 3
AIS3	Injury AIS Position 4
AIS4	Injury AIS Position 5
AIS5	Injury AIS Position 6
AIS6	Injury AIS Position 7
AIS7	Injury AIS Position 8
AIS8	Injury AIS Position 9
AIS9	These are the full AIS (Abbreviated Injury Scale) values.
AIS_CODE	This is the type of anesthetic used.
ANESTHETIC	These are the scene arrival dates.
ARRIVAL_DATE	This is the time from response to the arrival.
ARRIVAL_DELAY	These are the times of arrival on the scene.
ARRIVAL_TIME	This is the ASA class.
ASA	This is the type of respiratory assistance.
ASSISTING	This is the NTDS code for ASSISTING.
ASSISTING_NTDS	This displays the last name of the Attending provider.
ATTENDING	This is the autopsy code. YY: done, charted; YN: done, uncharted; N: not done.
AUTOPSY	This is the autopsy report identification number.
AUTOPSY_ID_NO	This is the status of the autopsy, ie: JCAHO codes.
AUTOPSY_STATUS	This is the amount of blood loss in CCs from injury time to definitive care.
BLOOD_LOSS	These are the amounts of blood lost in CCs from procedures.
BLOOD_LOSSES	This is the patient's blood type: OPOS (O+), ONEG (O-), etc, and UNK (unknown)
BLOOD_TYPE	This is an explanation of the bypass situation.
BYPASS_EXPLANATION	This is the patient category.
CATEGORY	This is the cause code. Refer to the CAUSE file.
CAUSE_CODE	This is the state report code from the CAUSE file.
CAUSE_CODE_SRC	This is a description of the cause of death.
CAUSE_DEATH	These are the ICD9 E codes for cause. 'E' is not required.
CAUSE_E_CODES	This is the first Cause_E_Code.
CAUSE_E_CODES1	This is the second Cause_E_Code.
CAUSE_E_CODES2	This is the Intention from the NCIPC mechanism and intention matrix
CAUSE_E_CODES_INTENT	This is the Intention from the NCIPC mechanism and intention matrix. First Ecode only.
CAUSE_E_CODES_INTENT1	This is the Mechanism from the NCIPC mechanism and intention matrix
CAUSE_E_CODES_MECH	This is the Mechanism from the NCIPC mechanism and intention matrix. First valid Ecode only.
CAUSE_E_CODES_MECH1	This is the name of the E Code
CAUSE_E_CODES_NAME	This is the NTDS trauma type base off the Primary Cause E Code mechanism and intention matrix. from Appedix 1 NTDS 1.2.5
CAUSE_E_CODES_TYPE_NTDS	Display the code, questions and answers for CAUSE.
CAUSE_QA_DISPLAY	This is the filled field for TOTAL.CHARGE.
CHARGE_TOTAL	Displays the data using the fields in the Check.Fields Account_Control record.
CHECKFIELDS	This is the type of child restraint used (NTDS07).
CHILD_RESTRAINT	This is the NTDS code for CHILD_RESTRAINT.
CHILD_RESTRAINT_NTDS	Tests codes for validity.
CODETEST	General comments.
COMMENTS	This is the CDM code for the comorbid condition.
COMORBID_CODE	

FIELDS USED (UPDATED 3/2012)

COMORBID_DESCRIPTION	This is the description of the comorbid condition.
COMP	These are descriptions of the complication codes.
COMP_DATE	These are the dates the complications occurred or were discovered.
COMP_LOCATION_CODE	These are where the complications occurred. Refer to NURSING.STATION file.
COMP_TYPE	These are the complication codes.
CONSULT	This is whether a consult call was made.
CONSULT_CALL_TYPE	This is the type of consult call.
CONSULT_COMMENTS	These are comments associated with the consult.
CONSULT_FACILITY	These are the facilities consulted by this institute.
CONSULT_NOTIFY_DATE	These are the dates the consult was called.
CONSULT_NOTIFY_TIME	These are the times the consult call was placed.
CONSULT_PROVIDER	This is the provider consulted.
CONSULT_REPLY_DATE	These are the reply dates for the consult call.
CONSULT_REPLY_TIME	These are the reply times for the consult call.
CONSULT_RESULT	These are the results of this consult.
CONTROLLED_RATE	These are the controlled respiratory rates at the time the Trauma Scores were taken.
COUNTY_STATE	This is the county or state code.
COUNTY_STATE_SRC	This is the state report code for COUNTY_STATE.
CRITIQUES	These are the critique codes found for the patient.
CRITIQUES_DESC	This identifies the critiques that were found and gives the code descriptions
CRITIQUES_FOUND	These are the critiques found for this patient. This may be different than the CRITIQUE_CODE or the CRITIQUES field
CRITIQUE_ACS	These are the ACS critiques as identified in the CRITERIA_SOURCE field.
CRITIQUE_ACS_SCORE	This is the minimum score for the ACS critique code from the CRITERIA code file.
CRITIQUE_AVG_SCORE	This is the average minimum score from the criteria file.
CRITIQUE_CLASS	This is the class for the critique from the criteria file.
CRITIQUE_CODE	These are the critique codes.
CRITIQUE_CODE_SCORE	This is the minimum score for the critique code from the CRITERIA code file.
CRITIQUE_COUNT	This is the number of critiques found for this record.
CRITIQUE_DATE	This is the date the critique was identified.
CRITIQUE_DESCRIPTION	These are descriptions of the critiques.
CRITIQUE_FACTORS	These are contributing factors.
CRITIQUE_FOUND	This is whether any critiques were identified for this patient.
CRITIQUE_GROUP	
CRITIQUE_ID	This is how or who identified the critique.
CRITIQUE_JCAH	These are the JCAH critiques as identified in the CRITERIA_SOURCE field.
CRITIQUE_JCAH_SCORE	This is the minimum score for the JCAH critique code from the CRITERIA code file.
CRITIQUE_LIST	This identifies whether a critique was found for this patient.
CRITIQUE_LOC_CODE	These are where the critiques occurred.
CRITIQUE_MGMT	This is the management category for this critique.
CRITIQUE_MIN_SCORE	This is the minimum score from the criteria file.
CRITIQUE_MIN_SCORES	This is the minimum score from the criteria file for each critique.
CRITIQUE_OUTCOME	This is the Outcome score for this review.
CRITIQUE_OUTCOME_FINAL	This is the final CRITIQUE.OUTCOME value (last non null value).
CRITIQUE_QA_DISPLAY	Display the code, questions and answers for CRITERIA.
CRITIQUE_RATE	This is whether this patient had any critiques, expressed as 100 if so and 0 if not
CRITIQUE_RESP	This is the provider responsible.
CRITIQUE_REVIEW	Whether patients with critiques also has reviews.
DATE	Today's date in print format for reports or merges.
DATE_OUT	These are the dates the agencies responded to the call.
DATE_REPLIED	These are the dates the physicians replied to the calls.
DBDOC_KEY_CHECK	Checks record key and data for possible corruption.
DC_DESTINATION_CODE	This is the discharge destination code, usually a FACILITIES code.
DC_DESTINATION_CODE_SRC	This is the state report code for DC_DESTINATION_CODE.
DC_DISPOSITION_CODE	This is the DC disposition code.
DC_DISPOSITION_CODE_NTDS	This is the NTDS code for DC_DISPOSITION_CODE.
DC_DISPOSITION_DESC	This is a description of the discharge disposition.
DEATH_DATE	This is the date of death.
DEATH_TIME	This is the time of death.
DEFAULT_AGE	This is the calculated age in display format.
DEFAULT_ER_TIME	Determines the amount of time in the ED from nursing unit data.
DEFAULT_ISS	This is the default (calculated) ISS.
DEFAULT_LOS	Determines the hospital length of stay.
DEFAULT_MD_TYPE	This is the providers' specialty.
DEFAULT_PROVIDERS_RESPONSE	This is the time from Hospital Arrival to MD Arrival.
DEFAULT_TOTAL_DAYS_ICU	The calculated time spent in all ICU units.
DEPARTURE_DATE	These are the dates the agencies departed from the scene.
DEPARTURE_TIME	These are the times the agencies departed from the scene.
DESTINATION_ARRIVAL_DATE	These are the dates the agencies arrived at the destinations.
DESTINATION_ARRIVAL_TIME	These are the times the agencies arrived at the destinations.
DIAGNOSES	These are the anatomic diagnoses.
DIAS_BP	These are the diastolic blood pressures; 'D' = doppler or 'P' = palpated.
DISCHARGE_CONDITIONS	These are the discharge condition codes. Refer to DISCHARGE.CONDITION file.
DISCHARGE_CONDITIONS_SRC	This is the state report code from the DISCHARGE.CONDITIONS file.
DISCHARGE_DATE	This is the hospital discharge date.
DISCHARGE_TIME	This is the hospital discharge time.
DISTANCE	This is the distance of travel or flight in miles.

FIELDS USED (UPDATED 3/2012)

DOA	This is whether the patient was DOA.
DOB	This is the patients date of birth.
DONATION_STATUS	This is the code for organ donations requested, granted, done.
DRG	This is the Diagnosis Related Group number from 1 to 473.
DX_KNOWN	How dx were known: S(surgery), A(utopsy), CT(scan), X(ray), E(amination), or H(history).
EDITS_FAIL	These are the failed edits for this record.
EDITS_INFO	This is the Star, Description and Code for the edit that are found.
EDIT_CODES	These are the edit codes for this record.
EDIT_LIST	These are the edit descriptions for this record with failed edits indicated by a star.
ED_ADM_DATE	This is the ED Admission date.
ED_ADM_TIME	This is the ED Admission time.
ED_DC_DATE	This is the ED discharge date.
ED_DC_TIME	This is the ED discharge time.
ED_DESTINATION_CODE	This is the Nursing Station or Facility that the patient was transferred to after the ED
ED_DISPOSITION_CODE	Entered ED Disposition Code.
ED_DISPOSITION_CODE_NTDS	This is the NTDS code for ED_DISPOSITION_CODE.
ED_OUTCOME_NTDS	This is the NTDS code for ED_OUTCOME.
ELIGIBILITY	These are the studies for which the patient is eligible.
EMPTY_FIELDS	These are empty fields (rows) for this record.
ER_ADMISSION_DATE	This determines the ER admission date.
ER_ADMISSION_TIME	This determines the ER admission time.
ER_DATE	This field writes the ER Admission Date in print format.
ER_DISCHARGE_DATE	This determines the ER discharge date.
ER_DISCHARGE_TIME	This determines the ER discharge time.
ER_DISPOSITION	This determines the ER or Trauma room disposition. If can't be determined
ER_NUMBER	This is the patient's ER number.
ER_TIME	This is the time the patient spent in the ER.
ETHNICITY	This is the ethnicity of the patient. It is different from the RACE.
ETOH	This is the value of the blood alcohol.
ETOHBR	This is the Breathalyzer ETOH value.
ETOH_VALUE	This is the value for ETOH: this field checks the ETOH field, then lab codes, then procedure codes.
EV	This is whether ETOH was evident in the patient: 'Y' for yes or 'N' for no
EV_NTDS	This is the NTDS code for EV.
EXPORTCHECK	Displays export data in converted (not internal) format.
EXTRICATION	This is whether extrication was performed.
EYE1	This displays the Scene eye opening value.
EYE2	This displays the ED eye opening value.
EYE3	This displays the referring eye opening value.
EYE_OPENING	These are the GCS eye openings: 1 = none, 2 = pain, 3 = voice or 4 = spontaneous.
FIELD_TIME	This calculates the time from injury to hospital arrival.
FINAL_DISPOSITION	This is the final disposition from the institute, based on DC.Disposition.Code or ED.Disposition. Uses UNK if no disposition can be found
FINDING_CODE	These are the codes for the types of finding.
FIRST_NAME	This displays the patient's first name in letter format (Aaaaa).
FLAG_SBP1	This is whether SBP1 is present and numeric.
FLUIDS_AMOUNT	These are the amounts of the fluids.
FLUIDS_DETAILS	These are details of the fluids.
FLUIDS_LOCATION_CODE	These are where the fluids were given. Refer to NURSING.STATION file.
FLUIDS_START_DATE	These are the dates the fluids were started.
FLUIDS_START_TIME	These are the times the fluids were started.
FLUIDS_STOP_DATE	These are the stop dates of the fluids.
FLUIDS_STOP_TIME	These are the stop time of the fluids.
FLUIDS_TYPE	These are the fluid codes. Refer to FLUIDS file.
FOLLOWUP_COMMENTS	This is comments regarding followup.
FRACTURES	These are the fracture status codes for the Pediatric Trauma Score.
FREQUENCY_CODE	These are the frequencies of the medications. Refer to the FREQUENCY file.
FROM_HOSPITAL	This is the facility from which the patient transferred.
FROM_HOSPITAL_SRC	This is the state report code for FROM_HOSPITAL (referring facility).
FSEXP	Functional Status Expression Score.
FSEXP_SRC	The state translation code for the Functional Status expression score.
FSFEED	Functional Status Feeding Score
FSLOC	Functional Status Locomotion Score
FSLOC_SRC	The state translation code for the Functional Status locomotion score.
GCS1	This calculates Glasgow Coma Scale for the scene.
GCS2	This calculates the Glasgow Coma Scale for the ED.
GLASCOW	These are the Glasgow Coma Scores that are filled if the components are not available.
GLASCOW2	This displays the ER entered GLASCOW.
GLASGOW	These are the Glasgow Coma Scores that are filled if the components are not available.
HEIGHT	This is the height of the patients in INCHES.
HISTORY_CODE	This is the code for disease or condition history.
HOME	This is a description of the patient's home situation.
HOSPITAL_ADDRESS	This field displays the address of the hospital from the FACILITIES file.
HOSPITAL_ARRIVAL_DATE	This is the date the patient arrived at the hospital.
HOSPITAL_ARRIVAL_DAY	This determines the day of the week of hospital arrival.
HOSPITAL_ARRIVAL_HOUR	This determines the hour of hospital arrival.
HOSPITAL_ARRIVAL_MONTH	This determines the month number of hospital arrival
HOSPITAL_ARRIVAL_QTR	This determines the Quarter number of hospital arrival.

FIELDS USED (UPDATED 3/2012)

HOSPITAL_ARRIVAL_TIME	This is the time the patient arrived at the hospital
HOSPITAL_ARRIVAL_YEAR	This displays the year of hospital arrival.
HOSPITAL_ARRIVAL_YEAR_MONTH	This is the 4-digit year and month of hospital arrival.
HOSPITAL_ARRIVAL_YEAR_QTR	This is the year and quarter of hospital arrival.
HOSPITAL_CODE	This is the institution number for the hospital.
HOSPITAL_DEPARTURE_DATE	This is the date the patient left the hospital whether as an inpatient or outpatient
HOSPITAL_DEPARTURE_TIME	This is the time the patient left the hospital whether as an inpatient or outpatient
HOSPITAL_DEPARTURE_YEAR_QTR	This is the year and quarter of hospital departure.
HOSPITAL_LOCATION	This field displays the city, state, and zip of the hospital from the FACILITIES file.
HOSPITAL_TRANSFER	This is whether the patient was transferred from another facility: Y (yes), N (no).
ICD9	These are the diagnosis ICD9 codes.
ICD9_1	Injury ICD9 Position 1
ICD9_10	Injury ICD9 Position 10
ICD9_2	Injury ICD9 Position 2
ICD9_3	Injury ICD9 Position 3
ICD9_4	Injury ICD9 Position 4
ICD9_5	Injury ICD9 Position 5
ICD9_6	Injury ICD9 Position 6
ICD9_7	Injury ICD9 Position 7
ICD9_8	Injury ICD9 Position 8
ICD9_9	Injury ICD9 Position 9
ICD9_AREA_NTDS	This is the calculated AIS region by ICD9 to try to match the NTDS Benchmark analysis.
ICD9_AREA_NTDS_AIS_GE3	This is the calculated AIS region by ICD9 to try to match the NTDS Benchmark analysis.
ICD9_CLASS	This is the ICD9 class (excludes fourth and fifth digits).
ICD9_PRIMARY	This is the first (primary) diagnosis ICD9 code.
ID	Patient record key.
INCLUDE_QTR	This is whether the case is included, based on criteria in YEAR.QTR format, as determined by whatever program is referenced in the Account_Control record INCLUDE
INCLUDE_REASONS	These are the reasons for inclusion or exclusion, as determined by whatever program is referenced in the Account_Control record
INDUST_ACC	This is whether the accident is an industrial accident or not.
INITIALS	This displays the patient's initials.
INJURY_DATE	This is the date of the injury.
INJURY_DAY	This determines the day of the week of injury.
INJURY_DETAILS	This is detail of the injury.
INJURY_ST	This is the state where the injury occurred.
INJURY_TIME	This is the time of injury.
INJURY_ZIP	This is the zip code of the location where the injury occurred.
INSTITUTE_LEVEL	This is the Adult or Pediatric designation level for this Institute
INSTITUTE_NAMESRC	Used for reports
INSTITUTE_NO	This is the institution number for the hospital.
INSTITUTE_NO_SRC	This is the state report code for INSTITUTE_NO.
INSTITUTE_REGIONAL	This is the Regional code for this institute.
INTUBATED	These are whether the patient was intubated when Trauma Score was done.
INTUBATED1	This displays the Scene Intubated value.
INTUBATED2	This displays the ED Intubated value. (Used in JCAHO).
INTUBATED3	This displays the Final ED Intubated value.
ISS	This is the Injury Severity Score.
LAB_CODE	These are the lab codes.
LAB_DATE	These are the dates the lab tests were performed.
LAB_LOCATION_CODE	These are the patient's locations when the lab tests were done (NURSING.STATION file).
LAB_METHOD	This is the method by which the lab test was performed
LAB_RESULT_TIME	This is the time the lab result was received.
LAB_TIME	These are the times the lab tests were performed.
LAB_VALUE	These are the lab values.
LAST_NAME	This displays the patient's last name in letter format (Aaaaaa).
LOC	These are the levels of consciousness at the time the Trauma Scores were taken.
LOCALE	This is a text description of the location of the accident or injury.
LOCATION	This is the ICD9 'E' geographic location code. Refer to LOCATIONS file.
LOCATION_SRC	This is the state report code for LOCATION (E849 code).
LOS	This is the patient's LOS (length of stay) in days.
MAX_AIS	This is the patient's maximum AIS value.
MAX_REGION	This is the region(s) associated with the maximum AIS.
MD_ARRIVAL_DATE	These are the dates the physicians arrived.
MD_ARRIVAL_TIME	These are the times the physicians arrived.
MD_CALL_TYPE	These are types of calls placed to the MDs.
MD_NOTIFY_DATE	These are the dates the physicians were notified.
MD_NOTIFY_TIME	These are the times the physicians were notified.
MD_RESPONSE_TIME	This calculates the MD response times (from notified to arrived) in hundredths.
MEDICAL_RECORD_NUMBER	This is the medical record number for the patient.
MED_CODE	These are the medications that were given.
MED_DOSE	These are the doses of the medications.
MED_INDICATIONS	This is whether the medications were indicated.
MED_LOCATION_CODE	These are where the medications were given.
MED_PROVIDERS	These are the codes of the physicians that ordered medications.
MED_REASONS	This is the reason the med was given. I.E., For antibiotics: 'T' if the medication was therapeutic or 'P' if it was prophylactic
MED_ROUTE	These are the routes that the medications were given.

FIELDS USED (UPDATED 3/2012)

MED_START_DATE	These are the dates the medications were started.
MED_START_TIME	These are the times the medications were started.
MED_STOP_DATE	These are the dates the medications were stopped.
MED_STOP_TIME	These are the times the medications were stopped.
MED_TYPE	These are the types of medication used.
MONTH	This determines the month number of hospital admission.
MOTOR1	This displays the Scene motor response value.
MOTOR2	This displays the ED motor response value.
MOTOR3	This displays the referring motor response value.
MOTOR_RESPONSE	These are the GCS motor values: 1= none, 2= ext, 3= flex, 4= withd, 5= local, 6= obey.
MRN	This is the patient's medical record number. It is generally the number that uniquely identifies the patient over all hospitalizations
NAME	This is the patients name: last name, first name, middle initial.
NAME_FIRST	This is the patient's first name.
NAME_LAST	This is the last name of the patient.
NAME_MI	This is the patient's middle name or initial.
NEAREST_TOWN	This is the town nearest to the injury.
NEUROSURGEONS	Neurosurgeons
NOTIFY_DATE	These are the dates the agencies were notified.
NOTIFY_DELAY	This is the time from injury to notification.
NOTIFY_TIME	These are the times the agencies were notified.
NTDS_EDITS_DATA	These are the NTDS Edits data.
NTDS_EDITS_FAIL	NTDS fail edits (level 1 or 2).
NTDS_EDITS_FAIL_DATA	These are the NTDS Fail Edits data.
NTDS_EDITS_FIELDS	These are the NTDS Edits fields.
NTDS_EDITS_INFO	NTDS Edits Information.
NTDS_EDITS_LEVEL	These are the NTDS Edits level.
NTDS_EDITS_MSG	These are the NTDS Edits message.
NTDS_EDITS_TAG	These are the NTDS Edits tag.
NUM_ADMISSIONS	This is the number of this admission in relation to previous hospitalizations
OCCUPATION	This is the patient's occupation.
OPEN_WOUND	These are the open wound status codes for the Pediatric Trauma Score.
ORGAN	These are the organs, systems, or activities that are evaluated for their functional status.
ORGANS_DONATED	These are the organs that were donated by the patient.
ORGAN_SRC	This is the state report code from the ORGANS file.
OR_DISPOSITION_CODE	OR disposition if patient went directly to the OR from the ED.
OUTCOME	This is the patient's outcome: 'A' or 'D'.
OUTCOME_SCORE	This is the Glasgow Outcome Score.
OXIMETRY	This is the percent blood Oxygen saturation.
P1	This displays the SCENE pulse rate.
P2	This displays the ER pulse rate.
P3	This displays the third pulse rate.
PARALYTICS	Were paralytic agencies given prior to GCS
PARALYTICS1	This displays the Scene paralytics given.
PARALYTICS2	This displays the ED paralytics given.
PARALYTICS3	This displays the Final ED paralytics given.
PATIENT_COUNT	This inserted a one in the report for summing.
PATIENT_NUMBER	This is the patient number.
PATIENT_TYPE	This is the patient type: trauma, cardiac, ob, etc.
PAYMENT_SOURCE	These are the payment sources.
PAYMENT_SOURCE_NTDS	This is the NTDS code for PAYMENT_SOURCE (value 1).
PAYMENT_SOURCE_SRC	This is the state report code for PAYMENT_SOURCE.
PED_TS	These are the Pediatric Trauma Scores.
PHONE	This is the patient's phone number.
PLACE_DEATH	This is where the death occurred.
PLACE_OF_DEATH	This displays the unit code where death occurred.
POSITION	This is the position of the patient in the vehicle.
POST_HOSPITAL	This is the type of treatment received after hospital discharge.
PREINJCOM	This is whether there was a pre-injury communication disability present.
PREINJLOC	This is whether there was a pre-injury locomotion disability present
PREVENTABLE	This is the preventability: Y (Yes), N (No), P (Possibly), NA (Not Apply), U (Unknown).
PROCEDURES	These are the procedure code descriptions from the Procedures file.
PROCEDURE_ANESTHESIA	These are the anesthesiologists or anesthetists.
PROCEDURE_ANES_START_TIME	This is the time the anesthesia care started.
PROCEDURE_ANES_STOP_TIME	This is the time the anesthesia care stopped.
PROCEDURE_ASSISTANT	These are the assistants for the procedure.
PROCEDURE_CODE	These are the codes for the procedures.
PROCEDURE_CODE_DESCRIPTION	This is the procedure description from the PROCEDURES file.
PROCEDURE_DAYS	Number of days from Hospital Arrival to the procedure.
PROCEDURE_DETAIL	These are descriptions of the procedures.
PROCEDURE_EPISODE	This is the episode indicator for the procedure.
PROCEDURE_ICD9	These are the ICD 9 codes for the procedures.
PROCEDURE_ICD9_DESC	This is the procedure description from the PROCEDURE_CODES file.
PROCEDURE_ICD9_GROUP	This is the Procedure ICD9 group (excludes third and fourth digits)
PROCEDURE_INDICATIONS	This is the indications for the procedure
PROCEDURE_LOCATION_CODE	These are where the procedure was performed.
PROCEDURE_ORDER_TIME	This is the time the procedure was ordered.

FIELDS USED (UPDATED 3/2012)

PROCEDURE_PROVIDERS	These are the provider codes for the procedures.
PROCEDURE_QA_DISPLAY	Display the code, questions and answers for PROCEDURES.
PROCEDURE_REASON	This is the reason for the procedure.
PROCEDURE_RESULT	These are the procedure results.
PROCEDURE_ROOM	This is the exact room number where the procedure was performed.
PROCEDURE_START_DATE	These are the dates the procedures were started.
PROCEDURE_START_TIME	These are the times the procedures were started.
PROCEDURE_STOP_DATE	These are the dates the procedures were stopped.
PROCEDURE_STOP_TIME	These are the times the procedures were stopped.
PROCEDURE_TYPE	These are special procedure prompts for the type of procedure or equipment used.
PROTECTIVE_DEVICES	These are the protections used, such as seat belt, car seat, etc.
PROTECTIVE_DEVICES_SRC	This is the state report code for PROTECTIVE_DEVICES.
PROVIDERS	These are the providers listed in PROVIDERS.CODES or PROCEDURE.PROVIDERS.
PROVIDERS_CODE	These are the codes for the providers on the case.
PROVIDERS_RESPONSE	This is the providers response time in minutes.
PROVIDERS_TYPE	These are the types or specialties of the providers caring for the patient.
PROVIDER_RESPONSE	Time to provider response in minutes.
PTS_AIRWAY	These are the Pediatric Trauma score airway values.
PTS_CNS	These are the Pediatric Trauma Score central nervous system values.
PULSE	These are the pulse rates.
PUPILS	These are pupil codes (1234): 1, 2 are L size and reaction; 3, 4 are right
RACE	This is the patient's race.
RACE_OTHER	This is the other (secondary) race designation for this patient.
RACE_SRC	This is the state report code for RACE.
RECORDER	This is the person who recorded the case.
RECORDSIZE	This is the size of the record.
RECORD_CHANGE_DATES	These are the change dates from the RECORD_DATE field.
RECORD_CHANGE_FIRST	These are who made changes from the RECORD_DATE field.
RECORD_CHANGE_USERS	These are who made changes from the RECORD.DATE field.
RECORD_COMPLETE_DAYS	This is number of days from the Hospital_Departure_Date to the Record_Complete_Date or the Record_Date_Last. No answer means the data was not available.
RECORD_ENTRY_LAST	This is who made the last change from the RECORD.ENTERED field.
RECORD_REVIEWS	These are the unresolved reviews at the time of finalization.
RECORD_SUMMARY	This is an mv array of summary flags that indicate why a record is still open
REFERRAL_TIME	This is the length of time spent at a referring hospital.
REFERRING_ADMIT_TYPE	This is the admit type at the referring facility.
REFERRING_ARRIVAL_DATE	This is the date the patient arrived at the referring hospital.
REFERRING_ARRIVAL_TIME	This is the time the patient arrived at the referring hospital
REFERRING_CONSULT	This is whether the patient had a Trauma Service consult at the referring hospital
REFERRING_CONSULT_DATE	This is the date of the Trauma Service consult at the referring hospital.
REFERRING_CONSULT_TIME	This is the time of the Trauma Service consult at the referring hospital
REFERRING_DISCHARGE_DATE	This is the date the patient was discharged from the referring hospital.
REFERRING_DISCHARGE_TIME	This is the time the patient was discharged from the referring hospital
REFERRING_HOSPITAL	This displays the name of the referring hospital from the DESTINATIONS file.
REFERRING_MD	This displays the last name of the referring MD.
REF_ARRIVAL_DATE	This is the arrival date at the referring facility. REFERRING.ARRIVAL.DATE checked first, if empty, looks for arrival date field in
REF_ARRIVAL_TIME	This is the arrival time at the referring facility. REFERRING.ARRIVAL.TIME checked first, if empty, looks for arrival time field in
REF_DISCHARGE_DATE	This is the discharge date at the referring facility. REFERRING.DISCHARGE.DATE checked first, if empty, looks for discharge date field in
REF_DISCHARGE_TIME	REF.PATIENTS file. This is the discharge time at the referring facility. REFERRING.DISCHARGE.TIME checked first, if empty, looks for discharge time field in REF.PATIENTS file.
REGION	These are the regions of injury.
REGION1	Injury REGION Position 1
REGION10	Injury REGION Position 10
REGION2	Injury REGION Position 2
REGION3	Injury REGION Position 3
REGION4	Injury REGION Position 4
REGION5	Injury REGION Position 5
REGION6	Injury REGION Position 6
REGION7	Injury REGION Position 7
REGION8	Injury REGION Position 8
REGION9	Injury REGION Position 9
REGION_SRC	This is the state report code from the AREA file.
REMINDER_COMMENTS	This is comments regarding the reminder.
REQUESTER	These are who requested the transports.
RESIDENT	This displays the last name of the Resident provider.
RESPONSE_DELAY	This calculates the times from notification to response.
RESP_RATE	These are the respiratory rates.
RES_CITY	This is the city of residence.
RES_COUNTY_STATE	This is the code for residence county or state.
RES_COUNTY_STATE_SRC	This is the state report code for RES_COUNTY_STATE.
RES_FIPS	This is the FIPS code of the residence.
RES_STATE	This is the state of residence.
RETURN_TIME	This calculates the times from departure to destination.
REVIEWER	These are codes for the reviewers.
REVIEW_ACTION	This is the action resulting from the review.

FIELDS USED (UPDATED 3/2012)

REVIEW_ACTION_TAKEN	These are the actions that were taken, excluding 'NONE'.
REVIEW_CATEGORY	This is the category of the review results. May be used for error codes.
REVIEW_COMMENTS	These are free text comments regarding the review. This is the multivalue version of this field so it can be used in a group
REVIEW_DATE	This is the date the review was performed.
REVIEW_DESCRIPTION	This is the description of the review.
REVIEW_DUE	This is the date a review action letter is due.
REVIEW_INIT	This is the date a review action letter was sent.
REVIEW_QA_DISPLAY	Display the code, questions and answers for REVIEWS.
REVIEW_RECEIVED	This is the date a review action letter was received.
REVIEW_RESP	This is the the responsible person to whom this review is directed
REVIEW_RESOLVE	This is the date this review was resolved.
REVIEW_SEQUENCE1	This is the first DateTime column for this sequence.
REVIEW_SEQUENCE2	This is the second DateTime column for this sequence.
REVIEW_SEQUENCE3	This is the first Detail column for this sequence.
REVIEW_SEQUENCE4	This is the second detail column for this sequence.
REVIEW_TOPIC	This is the topic (a critique code) for this review.
REVIEW_TREND	This is the trend note for this review.
REVIEW_TYPE	This is the type of review performed.
REVIEW_UNRESOLVED	Whether the review was resolved or not.
RISK_FACTOR	These are descriptions of the risk factors.
RISK_QA_DISPLAY	Display the code, questions and answers for RISKS.
RISK_TYPE	These are the risk factor codes.
ROOM_ASSIGN	This is the time room assignment was made.
RPS	This calculates all Revised Probabilities of Survival.
RPS1	This calculates the Scene Revised Probability of Survival.
RPS2	This calculates the ER Revised Probability of Survival.
RPS3	This calculates the One-Hour Revised Probability of Survival.
RR1	This displays the SCENE respiratory rate.
RR2	This displays the ER respiratory rate.
RR3	This displays the third respiratory rate.
RTS	This displays the Revised Trauma Scores.
RTS1	This calculates the Scene Revised Trauma Score.
RTS2	This calculates the ER Revised Trauma Score.
SBP2	This displays the ER systolic blood pressure.
SBP1	This displays the SCENE systolic blood pressure.
SBP3	This displays the third systolic blood pressure.
SCENE_TIME	This calculates the times at the scene (from arrival to departure) in hours and minutes
SEVERITY_METHOD	This is the severity coding methodology.
SEX	This is the patient's sex or gender.
SEX_NTDS	This is the NTDS code for SEX.
SOCIAL_SECURITY_NUMBER	This is the patient's social security number.
SPEED	This is the speed of the vehicle at the time of the accident.
SPEED_CATEGORY	This is the speed category: 1 = low (0-30), 2 = moderate (30-55) or 3 = high (>55).
SYS_BP	These are the systolic blood pressures.
TEAM_LEVEL	This is the level of team activation.
TEAM_NOTIFIED	This is whether the trauma team was notified or not.
TEAM_NOTIFY_TIME	These are the times of team notifications.
TEMP	This is the patient's temperature.
TEMPS	These are the patient's temperatures.
TEMP_ROUTES	These are the routes the temperatures were taken. Refer to ROUTES file.
TICKLER	This is whether there are any reminders (ticklers) in effect.
TIME_OUT	These are the times the agencies responded to the call.
TIME_REPLIED	These are the times the physicians replied to the calls.
TIME_TO_PROCEDURE	Time to procedure start in minutes.
TITLE	This is the patient's title or salutation.
TOTAL_DAYS_ICU	This is the total number of days spent in ICU units.
TOTAL_DAYS_STEPDOWN	This is the total number of days spent in Stepdown units
TOTAL_SCENE_TIME	This is the time from earliest arrival to last departure.
TOX	This is the toxicology (drug screen) results. Separate with a comma (for lab compatibility).
TOX_TEST	This is whether Toxicology was tested.
TOX_TEST_NTDS	This is the NTDS code for TOX_TEST.
TOX_VALUE	This is the value for TOX: this field checks the TOX field, then lab codes, then procedure codes.
TRACKING_NO	This is the patient's Tracking Number.
TRANS	This is the transport code.
TRANSFER_MODE_SRC	This is the state report code for the transfer mode from the referring facility.
TRANSPORT_AGENCY	Name of final transport.
TRANSPORT_AGENCY_CODE	This is the transporting agency code.
TRANSPORT_AGENCY_CODE_SRC	This is the state report code for TRANSPORT_AGENCY_CODE.
TRANSPORT_AGENCY_UNIT	These are the unit identifications for the transporting agencies.
TRANSPORT_COMPLETED	These are whether the transport was completed.
TRANSPORT_DELAY	These are reasons for a delay in transportation.
TRANSPORT_DESTINATION	These are the transport destinations.
TRANSPORT_ID	This is the ID from the Transports file (synonym of DATABASE_ID).
TRANSPORT_LEVEL	These are the levels of life support available.
TRANSPORT_METHOD	This is the method of transport: such as Ambulance, Helicopter, etc. for this transport leg
TRANSPORT_ORIGIN	These are the origins of the transport segments.

TRANSPORT_RECORD_NO	This is the patient's transport record number (transport ID number)
TRANSPORT_SEQ	These are the transport sequence numbers. TRANSPORT_STATUS_CODE
	These are the patient status or condition codes during the transport
TRANS_OTHER	These are other types of transports that were used for this patient. TRANS_SRC
	This is the state report code for TRANS.
TRAUMA_NO	This is the patient's Trauma Number.
TRAUMA_SCORE_LOCATION_CODE	These are where the Trauma Scores were measured (NURSING.STATION file).
TRAUMA_TYPE	This is the type of the dominant injury.
TRIAGE_CODES	These are the triage codes.
TRIAGE_IDENTIFIED	This is who or what identified this triage code or reason.
TRIP_FORM	This is whether the trip form was completed.
TRSURG_PT_RESPONSE	Trauma surgeon response time.
TRSURG_RESPONSE_TIME	Trauma surgeon response time.
TRTS	This displays the Triage Revised Trauma Scores.
TRTS1	This calculates the Scene Triage Revised Trauma Score.
TRTS2	This calculates the ER Triage Revised Trauma Score.
UNIT_ADMIT_DATE	These are the dates the patient was admitted to the nursing units
UNIT_ADMIT_TIME	These are the times the patient was admitted to the nursing units
UNIT_CODE	These are the codes for the nursing units.
UNIT_DC_DATE	These are the dates the patient was discharged from the nursing units
UNIT_DC_TIME	These are the times the patient was discharged from the nursing units.
UNIT_DISCHARGE_CONDITION_CODE	These are the unit discharge condition codes.
UNIT_DISPOSITION_CODE	These are the unit disposition codes.
UNIT_REASON	This is a text description of the reason for admission to this unit.
UNIT_TIME_DISPLAY	This calculates the times on each unit and display in hours and minutes if less than 1 day or days
UNIT_TIME_TOTAL	This accumulates the time on each unit.
VENTDAYS	The number of days on a ventilator.
VENTDAYS_NTDS	The integer number of Vent days.
VENTDAYS_UNIT	These are the units where the VENT procedure occurred.
VENTDAYS_UNIT_TIME	This is the time in days for each unit for the VENT procedure.
VERBAL1	This displays the Scene verbal response value.
VERBAL2	This displays the ED verbal response value.
VERBAL3	This displays the referring verbal response value.
VERBAL_RESPONSE	These are GCS verbal responses: 1= none, 2= incomp, 3= inapp, 4= confused, 5= oriented.
VS_DATE	These are the dates the vital signs were measured.
VS_LOCATION_CODE	These are where the Vital Signs were measured.
VS_NUMBER	Vital Sign numbers: scene (1), ER (2), One-Hour (3). Decimals are extra scores.
VS_O2	This is the amount of oxygen administered. VS_TIME These
are the times the vital signs were measured. WEEKDAY	This is the hospital arrival weekday.
WEIGHTS	These are the weights of the patient.
WEIGHTS_UNITS	These are the weights units: 'P' for pounds or 'K' for kilograms.
YEAR	This displays the year of hospital admission.
YEAR_QTR	This is the year and calendar quarter of admission.date.
ZIP_CODE	This is the patient's Zip Code.

Glossary of Terms

CODE_GROUPS	Code_Groups are groups of fields displayed in a folder during data entry. The Data Dictionary contains views of these code groups and from here you can determine the FILE and FIELDS used in a particular screen. If you need to adjust a Code_Group you can get to these by going to the MAIN MENU and selecting 'Codes' → Code Groups → find the name referenced in your appendix and enter → Group tab. It is advised that you do not delete fields from the group, but rather turn them off by putting a 'N' in the 'Entry' column. Use your <right click> to access the sort function for this list of fields. NOTE: DO NOT MOVE THE FIRST FIELD POSITION IN ANY CODE GROUP.
COMPLICATIONS	This file can be accessed from the MAIN MENU by selecting 'Patterns' → select 'COMP'; also from data entry if you are on the complications fields use <ALT><F2>. Notice that all complications have a mapping code in place for NTDS, so, if you are adding to this file you must map your new codes to established NTDS codes so that when data is exported to NTDS the correct correlation will be made and sent. If you do not want some of your complication codes it is recommended that you turn the code off instead of deleting it from the system. To turn a code off go to the ACTIVE column and place a 'N' on the row you wish to inactivate. NOTE: NOT ALL COMPLICATIONS YOU ASSIGN TO A PATIENT HAVE TO GO ON TO REVIEW. IF YOU DON'T WANT TO REVIEW A COMPLICATION DO NOT SELECT IT WHEN YOU GET TO THE REVIEW FOLDER IN DATA ENTRY.
CQI	CQI stands for Continuous Quality Improvement. This acronym is often replaced by other abbreviations such as PI (Performance Improvement), QI (Quality Improvement), PIPS (Performance Improvement and Patient Safety). In general this acronym represents the process of reviewing patient care for quality improvement within your facility.
CRITIQUES	Critiques is often now referred to as 'Issues', however, 'Issues' can be more than just critiques. Critiques is a code file that can be accessed by going from the MAIN MENU to 'Codes' → 'Select Codes' → 'Criteria'. You can also access this code file during data entry by using your <ALT><F2> field from the Critiques field. The Critiques/Criteria code file contains both entered (E) and computed (C) types of codes. Entered Critiques are those that you would enter into a patients record when you identify them; Computed critiques will automatically be assigned to a patient if the system finds programmatically they should have this tagged to their record. An example of a computed critique would be 'DEATH'; the code could be entered during data entry in the critiques folder for a patient, or, the database will automatically assign the code to the patient since it can programmatically look at the field 'OUTCOME' and see if there is a 'D' for death in the field. When using <F2> from your Review's folder both entered and computed critiques will be shown. If you want to make a critique computed and are unsure please refer to CDM's documentation on Critiques, and/or call support for assistance. NOTE: DO NOT DELETE CRITIQUES, INSTEAD TURN THEM OFF. TO TURN OFF MANY CODES IN A FILE FROM THE MAIN MENU SELECT 'CODES' → 'MAKE CODES ACTIVE' -> SELECT THE CRITERIA FILE AND TOGGLE BETWEEN OFF AND ON.
FILES	A FILE is where data is kept for a specified topic. Files contain FIELDS and these fields are used during data entry, reporting, exporting and several other areas.

ISSUES	These are the review topics you have tagged as items needing to go through part or all of the review process. Some ISSUES will be closed right from the patients data entry scree, some will be resolved in your PIPS screen, and others will go through one or more meetings. Issues tagged to a patient should be resolved for patients in a timely and thought through manner. If you are able to prove your process there your site reviews will be much more efficient in this respect.
MERGES	This is a one-record per merge report. If you choose a merge for a patient you are asking to report on the data for just one patient. You can run a merge on a group of patients, however, you will be making one merge on each patient in the group.
PATIENTS	This is the file where patient information on a particular event is captured. It uses both the patient data entry screen and the PIPS screen. The dictionary for this file is very large, the largest file CDM systems uses.
PATTERNS	Patterns are where your pick-list resides; pick-list can be accessed from fields with patterns by using your <F2> key. From data entry you can change your patterns by going to the field and pushing your <ALT><F2> key. It is recommended that you do not remove a code within a pattern, but rather, turn it off by putting in 'N' in the active column in the pattern.
PROVIDERS	All providers, including non-physician staff, are kept within the PROVIDERS code file. Use your <F2> during data entry to see all active providers. You can also get to the providers list by going from the MAIN MENU to Codes → 'Select Codes' → Providers. NOTE: DO NOT DELETE PROVIDERS, INSTEAD TURN THEM OFF. TO TURN OFF MANY CODES IN A FILE FROM THE MAIN MENU SELECT 'CODES' → 'MAKE CODES ACTIVE' -> SELECT THE PROVIDERS FILE AND TOGGLE BETWEEN OFF AND ON.
REPORTS	Reports can also be accessed from your 'Report Library', this can be found from the MAIN MENU 'Reports' choice. In addition you can see many reporting engines built into your systems, this is where you could adjust an existing report or make a new report. It is important to remember that when using a report you select the correct file where the data is kept. Most reporting will use the PATIENTS file.
SCREENS	Screens are the code groups within a file that are accessed during data entry. Often called 'Folders', because they look like folders on your main data entry screen for a patient, these screens can be adjusted to suit your facilities needs by going to the code group for the screen. You are able to change labels, sort fields, add fields, turn fields off, remove fields from code groups.